University of Alberta

# PERCEPTIONS OF A CHANGE PROCESS: THE DEVELOPMENT OF A NURSING GOVERNANCE MODEL

by

BRENDA MARJORIE ARNETT MCLEAN

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of MASTER OF EDUCATION

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Dr. Beth Young (Supervisor)

Dr. Frank Peters (Supervisor)

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DECEMBER 12, 1994

## DEDICATION

**This thesis is dedicated to my father**

**John Leslie Arnett**

**May 11, 1918 to March 20, 1993**

**"A child's smile makes it all worthwhile."**

*He lived his life as he believed it should be lived, guided by his spirit of giving, an honest day's work, fair play and good sportsmanship. He valued his family, his friends, his career and his volunteer work. He will be greatly missed and always remembered by all who knew and loved him.*

## ABSTRACT

The purpose of this study was to identify and describe a change process used to develop a model of nursing governance in a large teaching hospital in Western Canada. The participants were the University of Alberta Hospitals' Nursing Governance Task Force which developed the C.A.R.E. Model of Nursing Governance. They were a cross-section of management, union representatives and staff. Data were collected from taped, semi-structured interviews.

The main findings were: a combination of graduate school and work experience enabled participants to recognize the benefits of change and facilitate the change process; members were motivated and committed to the process; decision-making was by consensus; facilitating factors were the attitudes of members, the availability of resources, and timing; hindering factors were attitudes of members and staff, fluctuating membership, and time constraints. Perceptions of the attitudes of management, unions and staff revolved around issues of power and control.

Recommendations for developing and implementing a radical "second-generation" change process were developed.

## ACKNOWLEDGEMENTS

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## LIST OF ACRONYMS

| | |
|---|---|
| ACHIEVE | University of Alberta Hospitals' Quality Improvement Program |
| C.A.R.E. Model | Co-operation, Accountability, Respect, Empowerment |
| CHCG | Canadian Health Care Guild |
| 2C | Committee on Committees |
| DMMTF | Decision-Making Model Task Force |
| DON | Director of Nursing |
| LPN | Licensed Practical Nurse |
| NA | Nursing Aide |
| NGTF | Nursing Governance Task Force |
| OT | Orthopedic Technician |
| QI Program | Quality Improvement Program |
| SNAA | Staff Nurses Association of Alberta |
| UAH | University of Alberta Hospitals |
| VPN | Vice President Nursing |

# CHAPTER ONE: INTRODUCTION

## Introduction to Shared Governance

Health care delivery systems are rapidly changing. Nurses, as providers of health care, are striving towards a strong autonomous professional nursing practice that will assist them in facing the new challenges of delivering care to meet clients needs. As nurses evolve in their professionalism, they develop increased autonomy, accountability and responsibility for defining, articulating and evaluating their practice. Through shared governance, nurses are seeking to have shared responsibility and involvement in all the decisions that govern their practice (Hibberd, Storoz, & Andrews, 1992; Perry & Code, 1991).

The process of change from a traditional hierarchical model of organization to a collaborative, decentralized decision-making model has been described as a "second-order change" (Cuban, 1988b in Fullen, 1991, p. 29). With a "second-order" change, the total organizational structure changes; this includes the philosophy, vision, goals, structure and roles of the members. The philosophy of shared governance is to involve nurses in collaborative decision-making at every level in an organization. This is a radical change from the traditional organizational structures that nursing has functioned under and it is difficult to plan and implement.

When a model of shared governance is implemented, processes create the opportunities for nurses to have the authority for decisions that affect their practice, and control over the implementation and outcomes of those decisions. They create an environment conducive to learning and the opportunity to collaborate with nursing colleagues and other health care professionals.

The traditional hierarchical model that nursing has functioned under both within nursing and within hospitals (Wilson, 1992), stifles and controls nursing practice, giving power to few and controlling many. An organizational structure that incorporates a model

of shared governance, empowers nurses to define their professional nursing practice, to maintain and develop continued competencies, and to take ownership of quality nursing care (Jones & Ortiz, 1989; McDonagh, Rhodes, Sharkey, & Goodroe, 1989; Miller, 1990; Nursing Council, University of Alberta Hospitals, 1991; Porter-O'Grady, 1987, 1989; Schindler, Pennack & McFolling, 1989; Storoz, 1989). In the United States, several hospital nursing divisions functioning with a shared governance approach in which organizational structures were flattened and power decentralized, and the role of the staff nurse in decision-making expanded, have reported the following positive effects: increased recruitment and retention of nurses, increased motivation to work, improved quality of work life, reduced absenteeism and increased organizational commitment (Howard, 1987; Jones & Oritz, 1989; McDonagh, Rhodes, Sharkey, & Goodroe, 1989; Perry & Code, 1991). Sheridan (1991) states that

> for nurses working in systems that use shared governance, research findings report positive outcomes, including increased power, autonomy, satisfaction, and enhanced professionalism. Self-esteem is bolstered, written and verbal communication skills improve, and ownership and investment in the success of the organization are increased.(p. 6)

With shared governance, autonomy, responsibility, accountability, job satisfaction and quality of work life become an inherent part of nurses' professional practice. Improved care delivery, lower costs and greater efficiency are additional benefits of shared governance.

The collaborative adoption of a model of shared governance promotes ownership by nurses which is best established through a process of planned development and guided change (Jacoby & Terpstra, 1990; Kreuger, 1989; Porter-O'Grady, 1989, 1992). Following the failed implementation of a model of shared governance that had been imposed without planned development or guided change (Hibberd, Storoz, & Andrews,

1992), The University of Alberta Hospitals' (UAH) Nursing Council chose to involve nurses from every level within the organization in the process of developing a model of nursing governance. The collaborative adoption and development of a model of shared governance would promote ownership by nurses which is best established through a process of planned development and change (Jacoby & Terpstra, 1990; Kreuger, 1989; Porter-O'Grady, 1989). This decision by Nursing Council resulted in the formation of the Nursing Governance Task Force, who were given a mandate to develop a model of nursing governance and to guide the planned implementation of the change within the Nursing Division.

Much of the current literature pertains solely to the implementation of shared governance models in the hospitals in the United States. There is little information which describes the development of structures and processes of a model of shared governance. There is also a lack of literature describing the additional challenge of involving a highly unionized nursing workforce in Canada in the development of shared governance models. The existing literature describes the various models of shared governance and the process of implementation, rather than the structures and processes used to develop a model.

## Purpose

The purpose of this study is to identify and describe the perceptions of the Nursing Governance Task Force (NGTF) members regarding a process used to develop the University of Alberta Hospitals' C.A.R.E. Model (Co-operation, Accountability, Respect, and Empowerment) of Nursing Governance.

This study is intended for a wide audience including the University of Alberta Hospitals' personnel, the University of Alberta Hospitals School of Nursing, the Staff Nurses Association of Alberta, the C.A.R.E. Model Evaluation Task Force, and stakeholders in the C.A.R.E. Model. As such it is intended as a comprehensive report on the range of perceptions of nursing staff on the process used by a major Canadian teaching hospital's nursing division to develop a model of nursing governance.

As there is little research available which documents the processes used to develop models of shared governance, it is hoped that the information obtained in this study may help clinical nurses and nursing administrators to better understand a shared governance structure, how a model of nursing governance can be developed, and the processes of change that are necessary to implement such a model. This information will add to the body of nursing knowledge from a Canadian perspective. It is hoped that other divisions and/or institutions, both nursing and non-nursing, both unionized and non-unionized, will be able to benefit from this study. Other groups targeted include other health disciplines, schools and social services agencies. Nurses, nursing administrators and nursing organizations may have a better understanding of the processes used to develop a governance structure within an organization as a result of the identification and description of the perceptions the processes undertaken by the NGTF members.

## Research Question

The main research question is: What are the current perceptions of the Nursing Governance Task Force members regarding the processes used to develop the University of Alberta Hospitals' model of nursing governance? To achieve the answer to the question, the following sub-research questions were developed:

1. What are the demographics of the participants (educational preparation, number of years in nursing, number of years employed at the University of Alberta Hospitals, and position currently held?
2. What motivated nurses to become involved in the process of developing a model of nursing governance? What motivated the members to remain on the task force?
3. What factors facilitated the process? What factors hindered the process?
4. Are the perceptions of staff nurses different from the perceptions of management and the unions?

## Definition of Terms

Shared Governance: "a process of collaborative decision-making for determining nursing policy and practice, and addressing issues that affect the Nursing Division "(Draft Statement on Shared Governance, University of Alberta Hospitals' Nursing Council, 1991).

## Methodology

Members of the NGTF of the University of Alberta Hospitals were interviewed and their current perceptions of the process used to develop the C.A.R.E. Model of Nursing Governance were analyzed. Interviews with the Task Force members were recorded, transcribed and analyzed by grouping of the recurring themes. Minutes of the NGTF and UAH Nursing Council meetings were reviewed.

## Delimitations

This study was limited to a description of the personal comments of the ten members of the NGTF. These ten participants were the total population of the NGTF. It describes their perceptions of the process that was used to develop the C.A.R.E. Model of Nursing Governance in the University of Alberta Hospitals' Nursing Division. Opinions of other personnel within the Nursing Division were not collected. This study did not address the implementation of the model nor was it an attempt to evaluate the model.

## Limitations

The data were collected one year after the NGTF completed its task. It is to be noted that the data were based solely on the recall of the events by members of NGTF. They did not have notes or minutes available during the interviews. To assist in establishing accuracy of their recall of the process, the participants were given the opportunity to review the transcribed interviews; to edit, add or delete information. The data that were collected was assumed to be sincere and valid as a result of the participants' relationship with the researcher which had been established during the development process.

## Researcher Bias

The researcher was a member of NGTF throughout the process of developing the model and was an advocate of the change to a shared governance model. In order to reduce the amount of researcher bias and influence on the interviewing process, every attempt was made to limit the amount of prompting by the researcher. This was achieved by the utilization of semi-structured interviews during which the researcher asked direct, open-ended questions. A conscious effort was made by the researcher to refrain from asking leading questions. Prompting about events or the process was kept to a minimum in order to avoid influencing the responses of the participants.

# CHAPTER TWO: BACKGROUND

The purpose of this chapter is to outline the background and purpose of the Nursing Governance Task Force (NGTF), its formation and the process that the NGTF engaged in. As well, the decision-making process and the C.A.R.E. (Co-operation; Accountability; Respect; Empowerment) Model of Nursing Governance are described.

## Background of the Nursing Governance Task Force

In 1989, the University of Alberta Hospitals' Nursing Division, with the support of the Hospitals' President, made a commitment to adopt a shared governance model as a means to reorganize the Nursing Division and enhance the professional practice of nursing. This process of change is referred to as transformation. The events of this change are outlined in A Chronology of Events (see Appendix A). Once the first model of shared governance was implemented, a variety of internal and external factors placed the new participatory decision-making model in jeopardy (Hibberd, Storoz & Andrews, 1992).

Internally, one of the factors was the arrival in 1988 of a Vice-President of Nursing (VPN) which signalled many changes within the Nursing Division. The incumbent VPN had retired after many years of employment with the Hospitals, during which time little change in the hierarchical structure in the Nursing Division occurred; the existing status quo had been maintained. One of the changes the new VPN made was to implement a model of shared governance in early 1989. The implementation of the model occurred rapidly, with a limited amount of information being disseminated to the nursing staff. The model was selected by the VPN without consultation or collaboration with the nursing staff. The staff felt that they had no ownership of the model nor any involvement in the process of transformation. The internal environment in the Hospitals could be described as stressful and strained.

Externally there existed a great deal of grass roots dissatisfaction among nurses, employers and the Government. An illegal strike in the Province, prior to the arrival of the

VPN, and drawn out negotiations between the Hospitals and the nurses' union, accentuated the dissatisfaction. Many nurses felt a lack of professional autonomy, accountability, and responsibility for issues related to patient care and their professional practice. In addition, budgetary cutbacks resulting in significant cuts in administrative positions and staff nurse layoffs added to the unrest and uncertainty within the Nursing Division.

Yet, throughout the internal and external changes, many staff nurses and nursing managers continued to be committed to the philosophy of shared governance as a means to guide their practice. When speaking of the attitudes of nurses and management regarding the concept of shared governance in nursing, Hibberd, Storoz and Andrews (1992) stated

> Many involved themselves in decision making, and acknowledged ownership of their practice and its problems. There was evidence of increased self-esteem and self-confidence as people engaged more in problem solving then in blame fixing. Nurses expressed a feeling of increased control over their work environment and a sense of purpose within the nursing division. Many developed new group interaction skills and increased their knowledge, allowing them to articulate their ideas and concerns effectively. At the same time they began to appreciate the hospital from a global perspective, understanding its problems and the context in which it functioned. (p. 11)

In the midst of this turmoil, the incumbent VPN had chosen not to have her contract renewed, and a new VPN was appointed from within the organization in June 1990. The existing Nursing Council, which had been formed with the implementation of the first model of shared governance, made a commitment to the concept of shared governance. The new VPN supported the stance that Nursing Council had taken and made a commitment to assist in the development of such a model.

## Formation of the Task Force

In May of 1991, a task force was formed and given the mandate to develop a model of nursing governance by October 1991 (Nursing Council, Minutes 2.91, February 1,

1991). This task force became the Nursing Governance Task Force (NGTF). The NGTF was comprised of staff nurses from all areas of the Hospitals, and representatives from the following groups: Nurse Educators, Nurse Managers and Directors of Nursing. Three ex-officio members, who represented major stakeholders in the Nursing Division, were added to the NGTF. They were the President of Local I of the Staff Nurses' Association of Alberta (SNAA), which represents all of the Registered Nurses who are employed at UAH, the President of the UAH Local of the Canadian Health Care Guild (CHCG), which represents Licensed Practical Nurses (LPNs), Nursing Aides (NAs) and Orthopedic Technicians (OTs), and the VPN. The Clinical Supervisor Group requested that a representative of that group be on the NGTF and a representative from that group was added.

In the initial stages of the formation of the task force, interested staff nurses were requested to submit their names to the VPN who selected the members for the group. As the group proceeded with their task, additional staff nurses were encouraged to join. The Chair and the Vice-Chair were staff nurses. The VPN, who was a proven group leader and facilitator, chose to act as the facilitator for the task force.

### The Process Undertaken by the Task Force

At their initial meeting in March 1991, the NGTF established a "critical path" (see Appendix B). This "critical path" listed the tasks that the NGTF identified needed to be accomplished, and outlined the timeframe in which the accomplishment of the tasks would occur. The NGTF identified that a literature search and review was necessary to provide all members with a base of common information regarding the subject of shared governance in nursing. They consulted with resource people who had observed models of nursing governance in action in both unionized and non-unionized hospitals in the United States. The NGTF determined early in the process the philosophy, mission and vision statements of the Nursing Division needed to be reworked so that they would reflect the concept of empowerment and decentralized decision-making (NGTF, Minutes: 5.91, May 9, 1991).

The philosophy, mission and vision statements of the Nursing Division needed to be congruent with the philosophy, mission, and vision statements of the Hospitals. The NGTF acknowledged that the reworking of the philosophy, mission and vision statements of the Nursing Division was a lengthy but necessary process. Once these statements had been reworked, the work began in earnest to develop a model of nursing governance.

Staff were consulted to gather information and information-dissemination sessions were planned to keep staff updated on the Task Force's progress. The NGTF agreed that evaluation of the model would begin after the implementation. In keeping with the concept of shared governance, decisions were to be arrived at by consensus. At no time during the process was a definition of consensus discussed nor was it ever determined if all of the members on the NGTF had the same meaning of consensus. The ex-officio members participated in the decision-making process.

The end results of the NGTF work consist of the C.A.R.E. Model of Nursing Governance, a philosophy of nursing, and a mission and a vision statement for the Nursing Division. This thesis will only describe the perceptions of the NGTF members regarding the process of the development of the C.A.R.E. Model of Nursing Governance.

The process used to develop the model of nursing governance was participative and evolutionary. The development process used "Tools and Techniques" from the University of Alberta Hospitals' Quality Improvement Program (UAH QI Program)[1] (Zenger-Miller, 1991). As an initial part of the QI Program, the Hospitals had sent a senior employee to Juran Institute in Wilton, CN to obtain training with these "Tools and Techniques": small

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[1] A site licence for a quality improvement program had been obtained from Zenger-Miller, Inc, (1991). Following the granting of the site licence, the University of Alberta Hospitals established their own Quality Improvement Program, ACHIEVE which embodied the Hospitals' core values of respect, partnership and continuous improvement. Henceforth in this study, this program will be referred to as the University of Alberta Hospitals' Quality Improvement Program (UAH QI Program) or ACHIEVE.

group work, setting of goals, brainstorming, "silent sorting", and "fish boning".[2] This senior employee became the Director of the UAH QI Program and initially trained other Hospitals' employees. Hospitals' employees then became the trainers of other employees in the QI process. The NGTF used these "Tools and Techniques" many times in the development process.

Members of the group had to establish a functional working relationship with each other. As they became familiar with each other and as they realized that they had a voice on the Task Force, they became productive, functioning members of the group. Once this occurred, members followed the "critical path" (see Appendix B) that they had established and became a cohesive working unit within the Nursing Division. Small group work, in cohorts of two or three, was utilized many times throughout the entire process to accomplish the following: 1) the literature search and review, 2) the reworking of the various components of the philosophy, mission and vision statements, 3) the composition and functions of the councils, 4) delineating a place and function within the new structure for existing committees and councils, and 5) the educational programs to educate staff regarding the model.

Part of the process at each meeting was to establish goals for the next meeting. By breaking the task into many small components, the group was able to accomplish the goals that they had established for themselves, and was able to accomplish the task of developing a model of nursing governance within the time frame given them by Nursing Council.

Brainstorming is a technique used to get ideas and issues onto the table for discussion. When brainstorming sessions were held the UAH QI Program Dialogue

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[2] The tools and techniques learned at the Juran Institute in Wilton, CN became a part of the University of Alberta Hospitals' Quality Improvement Program. Henceforth in this study, these tools and techniques will be referred to as the University of Alberta Hospitals Quality Improvement "Tools and Techniques" (UAH QI "Tools and Techniques").

Ground Rules[3] were used to guide the discussion (see Appendix C). These Dialogue Ground Rules were guidelines for constructive communication and had been adopted by the Hospitals as part of their QI Program, ACHIEVE.

"Silent sorting" (a UAH QI Program "Tool and Technique") was used following brainstorming sessions to identify and classify common themes. Ideas or issues were written on small pieces of paper and the NGTF was asked to sort them into groups or themes. No one was allowed to speak. The exercise was completed when no further sorting occurred. This technique allowed for all opinions to be considered in the grouping of ideas and issues. This technique was used in the rewriting of the Nursing Division's Philosophy of Nursing and for outlining the functions of the councils.

"Fish Boning" (a UAH QI Program "Tool and Technique") is a technique that was introduced to the NGTF by a facilitator from the Hospitals' QI Department. Following brainstorming and "silent sorting", a common theme was identified as the "backbone of a fish". Issues related to that theme became the major parts of the fish's skeleton. As related, but less important ideas were expressed, these ideas became smaller bones in the framework. This technique was used in the in the rewriting of the Nursing Division's Philosophy of Nursing.

On October 3, 1991, members of the NGTF presented their work to the Nursing Council (Nursing Council, Minutes: 8.91, October 3, 1991). Following the acceptance of the model, the NGTF requested that they be allowed to remain as a functioning group to guide the implementation of the model which was to begin early in 1992. This would commence with the development of the decentralized councils and continue throughout the year with the development of the four divisional councils. NGTF anticipated that it would be approximately five years before all of the councils in the C.A.R.E. Model would be

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[3] The Dialogue Ground Rules were developed by the University of Alberta Hospitals Quality Improvement Program ACHIEVE for use within the Hospitals at meetings at every level of the organization.

functioning effectively and the staff at the Hospitals had bought into the transformation process.

During the winter of 1992, the NGTF embarked on a variety of tasks. Many information sessions were held with staff in an attempt to inform them about the model and its applications. Questions were fielded and answers provided at open forums, union meetings and in the monthly NGTF Newsletter. Attempts were made to define staff nurses' decisions as opposed to corporate decisions. A contest was held to name the model and the staff nurses adopted proprietary ownership. The VPN suggested that Task Force members might benefit from the University of Alberta Hospitals' Quality Improvement Programs. Those members who had not been involved in any of the UAH QI[1] Programs, ACHIEVE, enrolled in Group Action[4]

In the February 1992, the VPN "suggested that NGTF propose to act as the Professional Council and then step aside as Decentralized Councils send representatives. In this way, the Professional Council would act as an informed resource to groups as they start up" (NGTF Minutes, Meeting No. 2.92, February 14, 1992). The NGTF concurred and forwarded this proposal to the existing Nursing Council, which approved the proposal in March, 1992 (UAH Nursing Council Minutes, Meeting No. 3.92, March 4, 1992). On May 1, 1992, "the NGTF would begin to be called the Professional Council, and *would* continue to work with governance work. New members will be welcomed to join the group until all Decentralized Councils can send their representatives" (NGTF Minutes, Meeting No. 6.92, May 1, 1992). NGTF became the first operational divisional council, the Professional Council. Its first task was to assist the other divisional councils to become

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1

[4] Group Action is a program within the University of Alberta Hospitals' Quality Improvement Program ACHIEVE. It offers information on how to work with groups, run successful meetings, introduction to team building and problem solving skills

operational in the Fall of 1992. Many of the original Task Force members became representatives of their decentralized councils on the divisional councils.

Throughout the entire development process, staff were kept informed of the work of the group through information sessions, news releases by electronic mail, messages distributed with paychecks, biweekly newsletters, information bulletin boards, and buttons and tee-shirts with a logo of the model. Feedback, both verbal and written, was elicited from all levels of staff at various stages throughout the process.

## Decentralized Decision-Making "Model"

Although literature supports decentralized decision-making, little information exists in the literature on the actual process used to develop models of shared governance which depend on decentralized-decision making. NGTF experienced difficulties in defining the decentralized decisions that nurses could make. This lead to the formation in March, 1992 of a sub-task force, the Decision-Making Model Task Force (DMMTF). This task force was composed of members of Nursing Council, NGTF, administration, and staff nurses at large (NGTF, Minutes: 4.92, March 6, 1992). Their mandate from NGTF was to look at developing a decentralized decision-making framework for the C.A.R.E. Model of Nursing Governance.

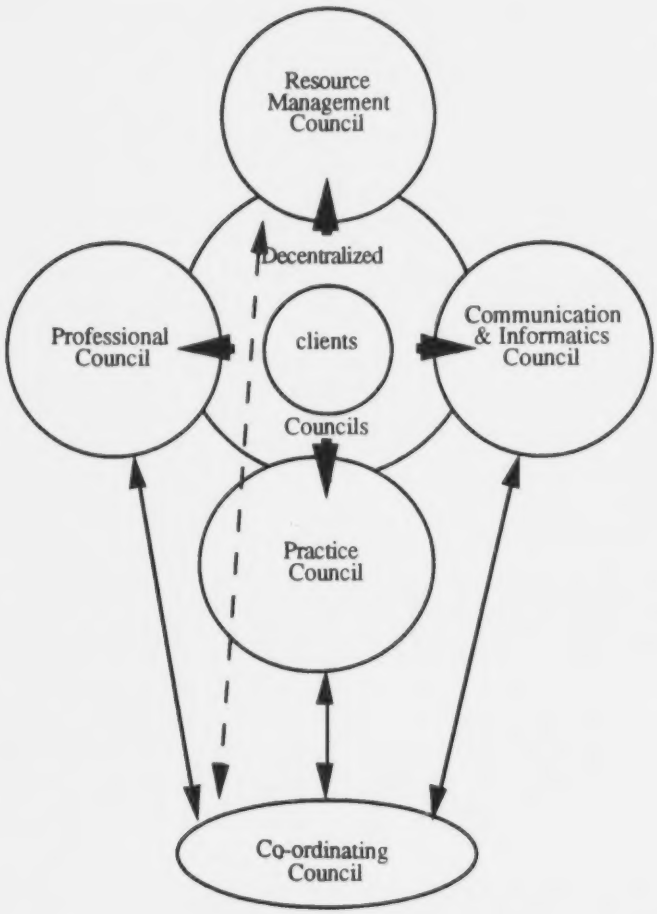
The framework that was developed by the DMMTF was a series of questions to guide the NGTF in the decision-making process (see Appendix D). These questions were used by the NGTF in drafting the generic terms of reference for the councils. However, the delineation of all the decisions that each council would have the authority to make remained unresolved. The NGTF decided that these issues, (e.g. layoffs, budget cutbacks) would be determined as the C.A.R.E. Model was implemented and the Divisional Councils began to address the issues.

## The C.A.R.E. Model of Nursing Governance

The C.A.R.E. Model (Figure 1) consists of patient-centered Decentralized Councils which are guided through the decision-making process by a Nurse Manager who acts as a

**Figure 1**

**University of Alberta Hospitals' C.A.R.E. Model of Nursing Governance**




October 1991
University of Alberta Hospitals' Nursing Governance Task Force

facilitator and key resource person to the process. The configuration of the Decentralized Councils was to be determined by the area staff within a management area. There could possibly be up to thirty Decentralized Councils. NGTF determined that the staff in the various management areas would be the determiners of the groupings which were to form the Decentralized Councils. The structure and membership of the Decentralized Councils was to be developed by the staff in the area to meet the needs of that area. The membership varied; some Decentralized Councils included everyone who worked in the area on the council (including Unit Clerks, Ward Aides, and Porters); others decided to elect representatives from each unit to form the Decentralized Council, and others determined that an interdisciplinary membership would meet their area's needs. The Decentralized Councils were to deal with issues that had a direct impact on the practice of nursing in their area. Each Decentralized Council placed one member on each of the four Divisional Councils (Professional, Resource Management, Communication and Informatics and Practice).

The Divisional Councils were developed to deal with broader, hospital-wide issues. The purpose of the Professional Council was to facilitate, co-ordinate and standardize activities that support the nursing philosophy, to enhance the professional worklife of nursing staff while incorporating the University of Alberta Hospitals' core values of respect, partnership, and continuous improvement. The Resource Management Council was to consider matters related to the employment of resources, human and financial, as they relate to the Nursing Division and to recommend direction in matter that affect the Nursing Division as a whole. The Communications and Informatics Council was to facilitate and co-ordinate communication and information dissemination within the Hospitals and external agencies; to define the role of computers in matters that affect the Nursing Division as a whole. The Practice Council was to facilitate and co-ordinate activities related to practice, multi-disciplinary collaborative care, and client support structures. The key resource people for the four Divisional Councils were to be the

Directors of Nursing. The Co-ordinating Council's functions were to share information and to co-ordinate the handling of issues at the divisional council level. It was to be composed of the chairs of the four Divisional Councils and the VPN. The Co-ordinating Council was to have no decision-making powers. The VPN was to be the facilitator for the Co-ordinating Council.

# CHAPTER THREE: A REVIEW OF THE LITERATURE

A number of shared governance models exist that empower nurses to define professional nursing practice, maintain continued competence, and take ownership of quality nursing care. The purpose of this literature review is to present an overview of (1) planned change, (2) definitions of shared governance, (3) examples of shared governance models, (4) commonalties and differences that exist between selected shared governance models, (5) the transformation to a shared governance model, (6) factors that facilitate transformation to a shared governance model, and (7) resistors to the implementation of a shared governance model.

## Planned Change

In reviewing the literature on planned educational change, Fullen (1991) states that "The nature of educational and social change must first be understood in terms of its sources and purposes" (p. 17). Levin (in Fullen 1991, p. 17) states that the sources of educational and social change come through natural disasters (earthquakes, floods), external forces (increasing complex technology, changing immigration patterns), and internal contradictions (changing social needs, a perceived discrepancy in values). The purposes for change come from the values (who benefits from the proposed change?) and the technical quality of the change (is the proposed change well planned?). Movement towards a change which affects both the culture and the structure of organizations evolves as a result of both external forces and internal contradictions. The pressures for organizations to react with planned change to those internal and external forces and contradictions are increased as society becomes more complex (Fullen, 1991, p. 17). The change can be imposed on organizations or voluntarily participated in or initiated when the organization experiences "dissatisfaction, inconsistency, or intolerability in [their] current situation" (Fullen, 1991, p. 31).

The change to a shared governance model is a total organizational restructuring resulting from both external forces and internal contradictions (Hibberd, Storoz, & Andrews, 1992). Cuban (1988b in Fullen, 1991, p.29) describes this form of change as a "second-order change". This change includes the redefinition of the organization's philosophy, vision, goals, structure and roles of the members. Most "second-order changes" fail as a result of poor planning and flawed implementation (Cuban,1988b in Fullen, 1991)

Marris (1975 in Fullen, 1991, p. 31) has stated "*all* real change change involves loss, anxiety, and struggle. Failure to recognize this phenomena as natural and inevitable has meant that we tend to ignore important aspects of change and misinterpret others". Fullen (1991) goes on to state that "New experiences are always initially reacted to in the context of some 'familiar, reliable construction of reality' in which people must be able to attach personal meaning to the experiences regardless of how meaningful they might be to others" (p. 31). Schermerhorn, Jr., Templer, Cattanoe, Hunt & Osbourne (1992) have stated seven reasons for resistance to change. They are "fear of the unknown, need for security, no felt need to change, vested interests are threatened, contrasting interpretations, poor timing, and lack of resources" (p. 537)

Change must have meaning for those affected for it to be effective and assimilated. Marris, as quoted in Fullen (1991) states that

> No one can resolve the crisis of reintegration on behalf of another. Every attempt to pre-empt conflict, argument, protest by rational planning, can only be abortive; however reasonable the proposed changes, the process of implementing them must still allow the impulse of rejection to play itself out. When those who have power to manipulate changes act as if they have only to explain, and when their explanations are not at once accepted, shrug off opposition as ignorance or prejudice, they express a profound contempt for the meaning of lives other than their own. For the reformers have already assimilated these changes to their own purposes, and worked out a

> reformulation which makes sense to them, perhaps through months or years of analysis and debate. If they deny others the chance to do the same, they treat them as puppets dangling by threads of their own conceptions. (p. 31)

In summing up the implications of change, desired or not, imposed or self-initiated, personal or collective, Fullen (1991, p. 32) states that the subjective meaning of change can be characterized by either ambiguity and uncertainty, or a sense of mastery, accomplishment and professional growth.

Real change is subjective to those involved. As House (1974 in Fullen , 1991) explains

> The personal costs of trying new innovations are often high... and seldom is there any indication that innovations are worth their investment. Innovations are acts of faith. They require that one believe that they will ultimately bear fruit and be worth personal investment, often without the hope of an immediate return. Costs are also high,. The amount of energy and time requires to learn new skills or roles associated with the new innovation is a useful index to the magnitude of resistance. (p. 34)

Because change can be subjective, people "*think* they have changed but have only assimilated the superficial trappings of a new practice" (Fullen, 1991, p. 35). Because change is subjective, it can be perceived as threatening, as Marris describes in Fullen (1991).

> Occupational identity represents the accumulated wisdom of how to handle the job, derived from their own experiences and the experience of all who have had the job before or share it with them. Change threatens to invalidate this experience robbing them of the skills they have learned and confusing their purposes, upsetting the subtle rationalizations and compensations by which they reconciled the different aspects of their situation. (p.36)

Just as change is subjective, it is at the same time objective, only because it exists outside any individual. The question has been posed by Fullen (1991, p. 37): Is this change real objectivity or is it merely the subjective conception of the producers of change?

Fullen (1991, p. 37) describes the planned change of any new program, policy, organizational structure as *multidimensional*. He outlines three dimensions of change that are necessary for implementation of planned change. They are: (1) the use of new or revised materials, (2) the use of new strategies or approaches, and (3) the possible alteration of beliefs. "Whether or not they do achieve the goal *(the planned change)* is another question depending on the quality and appropriateness of the change of the task at hand" (Fullen, 1991, p. 37). Change must be meaningful to those involved in the change for the implementation to be successful. Both the change and the change process must be understood.

## Definitions of Shared Governance

In the literature on organizational behavior, terms of shared governance, participative management, participative decision making and collaborative government are synonymous and they have been described (Callahan & Wall, 1987; Kabb 1990; Owens 1991; Umstat 1988). These definitions describe the process, but not the context.

Yukl, as cited by Callahan and Wall (1987, p. 218) describes four types of decisions that can be used separately or in combination.

1. *Autocratic decisions* are made by the leader without asking for the the opinions or suggestions of subordinates; subordinates have no direct influence.
2. *Consultative decisions* involve subordinative opinions and suggestions given to the leader; however, the leader makes the final decision alone. Subordinates have limited influence.
3. *Joint decisions* are group decisions with the leader meeting with a subordinate or with a group of subordinates to discuss a problem and to make a decision

together; the leader has no more influence than the subordinate(s) in the final choice.

4. *Delegation decisions* are made by the subordinates, after the leader delegates the responsibility and authority to them. Limits within which the final choice must fall are usually specified, and the subordinates may or may not be required to obtain leader approval before implementing the decision.

The one form of decision-making that is compatible with shared governance is *joint decisions.*

Callahan & Wall (1987) define participative management as "a management style or type of decision making procedure in which subordinates are allowed some measure of influence in the manager's decision" (p. 9). Jeuchter (in Callahan & Wall 1987, p.10) states that "group members contribute ideas and participate in the decision-making process, but it is the leader that guides the process through the use of skills as a synthesizer and coordinator"

Owens (1991), defines the participative decision-making process as "the mental and emotional involvement of a person in a group situation that encourages the individual to contribute to group goals and then share the responsibility for them" (p.284). In describing the process, Owens outlines "two major potential benefits: (1) arriving at better decisions and (2) enhancing the growth and development of the organization's participants (for example, greater sharing of goals, improved motivation, improved communication, better-developed group process skills)" (p. 284).

Umstat (1988) defines participation in decision-making as "the process of joint decision-making by two or more parties. This definition implies that all involved people contribute in some way to the decision" (p. 354). Umstat adapted the Vroom-Yetton Model of Decision-Making to identify six decision-making options which are:

1. Make the decision yourself based upon the information available (called *Autocratic I*)
2. Obtain the information from subordinates, but make the decision yourself (called *Autocratic II*)..
3. Get ideas and suggestions from your subordinates on an individual basis and then make your decision, which may or may not reflect subordinates' inputs (called *Consultative I*)..
4. Share the problem with your subordinates as a group to get their collective inputs and ideas. Again, the decision may or may not reflect subordinates' inputs (called *Consultative II*).
5. Share the problem with your subordinates as a group and jointly develop a decision which reflects the consensus of everyone in the group. Your role in this case is like a "chair" rather then a "boss"; you try not to influence the group towards a solution (called *Group*).
6. Delegate the decision to the individual or group with full authority for making the decision (p. 355).

The decision-making option that complements a shared governance model is the *Group* process.

The nursing literature defines shared governance as participative management (Jones & Oritz, 1989; McDonagh, Rhodes, Sharkey, & Goodroe, 1989; Miller, 1990; Nursing Council, University of Alberta Hospitals, 1992; Porter-O'Grady, 1987, 1989; Schindler, Pennack & McFolling, 1989; Storoz, 1989). All these definitions support involvement by nurses. The amount and the type of involvement by staff nurses and management varies within each definition and the context to which it is applied.

Porter-O'Grady (1987, Part I, 1991) defines shared governance as a model of delivery of nursing service which involves nurses at every level of practice within an organization. It allows others to participate in decisions over which someone else has control. It is accountability with authority, autonomy, responsibility and control for decisions related to professional nursing practice. "Authority and accountability are shared in a systematic format among all members of the nursing department" (Porter-O'Grady,

1989, p.350). By being actively involved in shared governance, nurses do not just participate, they establish ownership of their role in their organization.

Jones & Oritz (1989) quote Pinkerton's definition "shared governance is the organizational structure that provides an environment for autonomous staff nurse practice" (p. 13). This structure allows nurses to benefit from increased autonomy, accountability, and responsibility in their clinical practice.

McDonagh, Rhodes, Sharkey, & Goodroe (1989) state that as a result of a mature, well-established shared governance system at Saint Joseph's Hospital of Atlanta, "a professional nursing organization [that] is able to articulate and define nursing practice and to make decisions within the facilities that serve the health care consumers" (p. 17). This professional nursing organization is based on individual accountability which fosters professional judgements.

Schindler, Pennack & McFolling (1989) define shared governance within the context of the work environment. They have identified that a setting which incorporates a shared power model, also promotes interdependence and cooperation and supports the professional nurse.

Storoz (1989) states that the concept of shared governance is founded on the belief that the positive effects of participative management, that have been successful in other organizations, can be applied to nursing with the intent of enhancing professional nursing practice by having clinical nurse practitioners assume greater responsibility, accountability and autonomy.

Miller (1990) offers several definitions of shared governance by other authors. He quotes Jeffery Hill (in *Georgia Nursing*, Sept.-Oct. 1986) who contends that shared governance is "based on a decentralized organizational structure which concentrated increased emphasis on principles of participatory management and the accountability of each individual nursing practitioner in those areas related to both the governance and the practice of nursing" (p.121). Miller (1990) refers to M.E. Peterson's definition in terms

of "participative decision-making systems which relinquish control and develop adult to adult interactions" and refers to shared governance as "power: power to control; power to decide; power to administer. Shared governance is a system to transfer power from the governors to the governed; from nursing management to staff nurse" (p.122).

Sheridan in 1991, defines shared governance as well as the scope of shared governance within an organization as "a professional practice model on a continuum of empowerment, with governance increasing as nurses become more empowered. Self-governance extends beyond issues of clinical practice, professional development, and quality improvement --- self-governance empowers nurses to address wages, hours, and working conditions" (p. 2).

In 1992, in a Draft Statement on Shared Governance, the University of Alberta Hospitals' Nursing Council (1991, February 1) described shared governance as a "process of collaborative decision making for determining nursing policy and practice, and addressing issues that affect the Nursing Division".

It has become increasingly difficult to define shared governance within the context of nursing without describing the philosophy and the organization within which the models function. The common elements in the definitions is that shared governance is both a process and a structure; it involves decentralized collaborative decision-making; and it requires increased responsibility and accountability of the members of the organization. Therefore the context in which the model is applied requires description and discussion.

## Models of Shared Governance in Nursing

The current, most widely recognized model of shared governance is Porter-O'Grady's model (Porter-O'Grady & Finnigan, 1984). According to this model, nurses are not participants but owners of the decentralized decision-making processes within an organization. Nurses assume and share an active role at every level of decision-making that affects nursing practice. Clinical nurses deal with issues of professional practice: quality of care, education, quality of work life and evaluation, recruitment and retention. Porter-

O'Grady (1991) identifies the key characteristics that are a fundamental part of the clinical nurse's role in a shared governance model. They are:

> ***Responsibility.*** The clinical professional nurse has the responsibility for all clinical nursing activities in the nursing service, and that accountability is nontransferable. The clinical nurse defines, delineates, creates, approves, and evaluates all activities that reflect acceptable nursing practice in the institution.
> ***Accountability.*** accountability for practice cannot be transferred from the clinical arena or controlled in any way outside the clinical framework. It cannot accrue to the manager.
> ***Commitment.*** The key to successful shared governance is commitment from every nurse throughout the organization. Shared governance does not just create key roles for nurses in the organization; it creates the expectation that all nurses will play a role and express accountability for what happens in the organization.
> (p. 464)

Just as the role of the clinical nurse is changing, so is the role of management changing. Management relinquishes power and becomes facilitators of the process of shared governance. The emphasis is placed on the participation and ownership of decisions; on the creation of an environment that fosters and supports this organizational structure; on the transformation of the organization and the professional practice of nursing. The organizational structure changes from a hierarchical design to a decentralized collaborative decision-making design.

## Professional Governance Frameworks

The literature identifies three generic professional shared governance frameworks. They are the councilor, congressional and administrative models of professional shared governance as identified and defined in the literature by Porter-O'Grady (1987) and Merker & Burkhart (1991). The councils, congresses, or cabinets, as characterized by each of these three models of shared governance respectively, set the direction of the nursing

organization. Many large health care institutions that have operationalized shared governance for their nursing divisions have modified one of these three models by defining the context in which it is applied. These frameworks address the elements that support professional nursing practice standards, quality assurance, competencies, continuing education, and governance (Porter-O'Grady, 1987, p. 284). The role of management and administration is to support and facilitate the internal nursing system of the organization and articulate it to the external consumer system.

**Councilar**

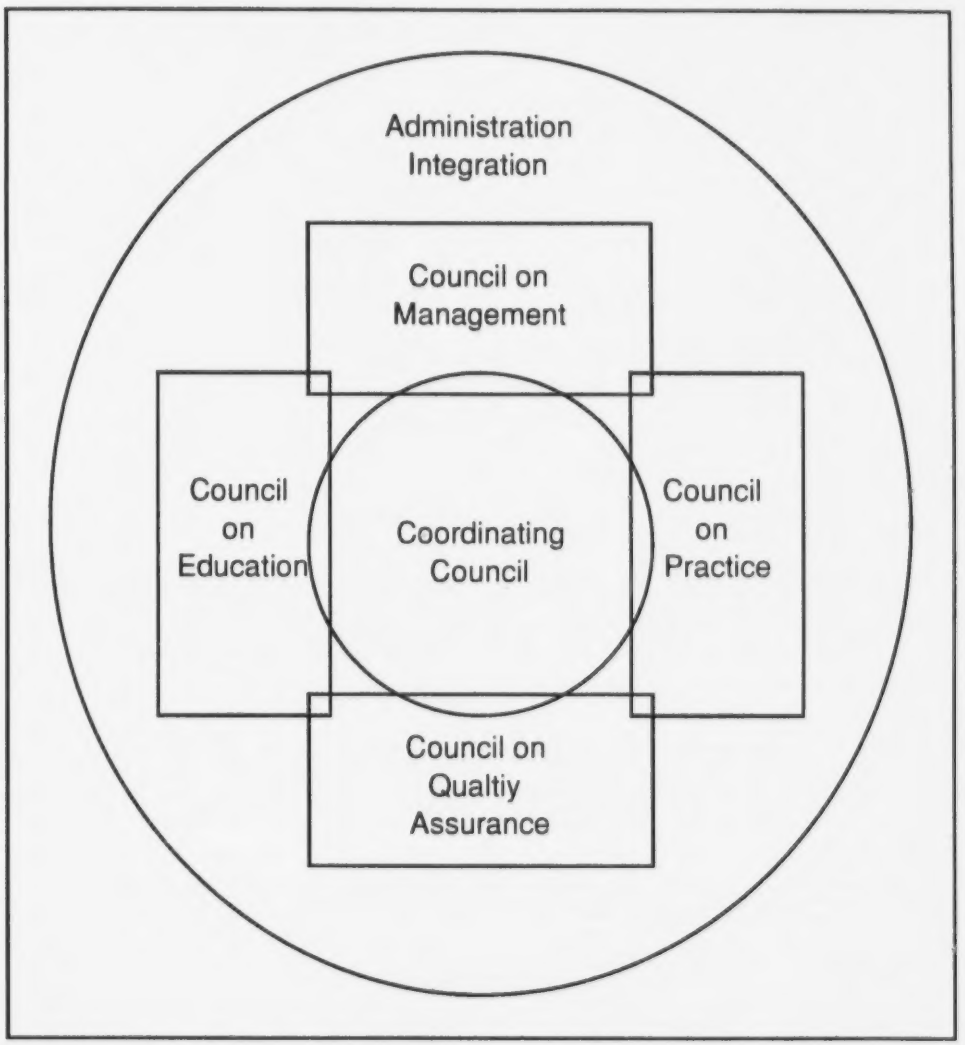
The councilar model (Figure 2) uses a council structure for governance processes for staff and management. Governing Councils are represented by nurses from each unit and from the other three councils. Ad hoc committees or subcouncils handle specific nursing issues. Each Council takes responsibility for a specific aspect of nursing practice: management, education, quality assurance, and practice. A Co-ordinating Committee consists of the chairs of the Governing Councils and the nursing administrator as the non-voting chair. They are charged with the responsibility of co-ordinating and supporting the functional aspects of the governance structure. The chair of the Co-ordinating Committee is a member of the hospital's governing board.

**Congressional**

In the congressional model (Figure 3), a President and a Nursing Cabinet are elected to control functions within the nursing organization. Cabinet members chair committees that deal with a variety of nursing issues: education, practice, peer relations, governance and quality assurance. The Cabinets, which function autonomously, report to the nursing executive and the nursing executive is a voting member of the hospitals governing board.

**Figure 2**

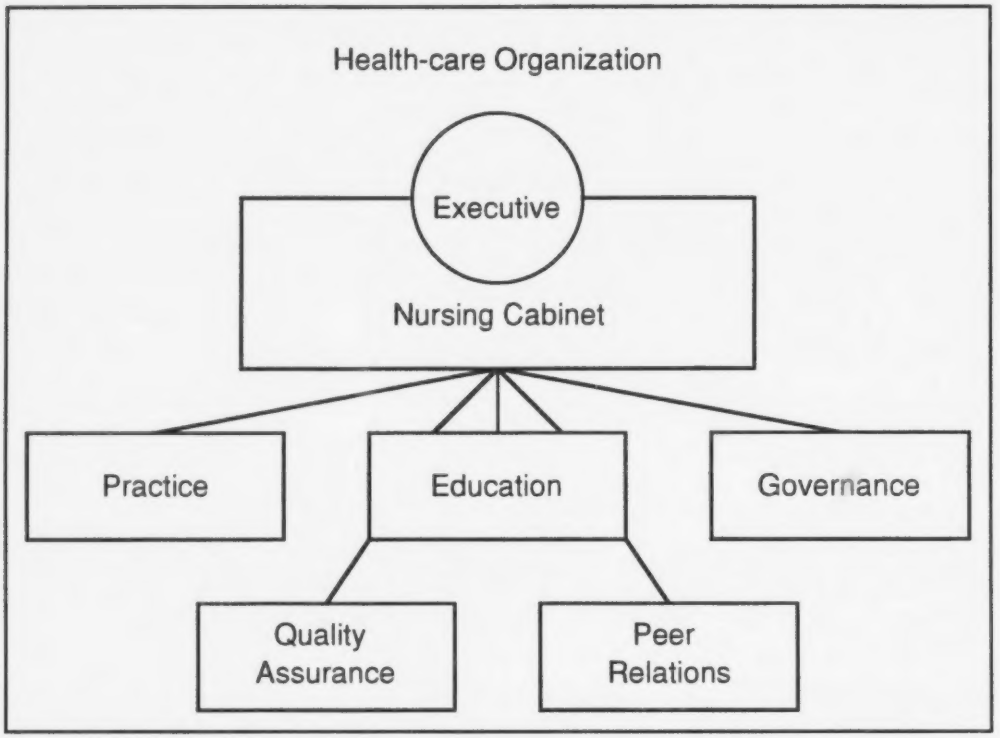
**Councilar Model of Nursing Governance**




Porter-O'Grady (1987) and Merker & Burkhart (1991)

**Figure 3**

**Congressional Model of Nursing Governance**




Porter-O'Grady (1987) and Merker & Burkhart (1991)

**Administrative**

In the administrative model, (Figure 4), a Management Forum and a Clinical Forum provide the context for the nursing organization. Management and staff hold elected positions on both forums. Management and staff hold elected positions on both forums. The Management Forum controls issues of finance, resources, and systems. The Clinical Forum controls issues of practice, quality and staff development. Both forums deal with peer relations issues. The nurse executive may or may not have veto power over decisions made by the forums, depending on the decision-making framework that has been adopted.

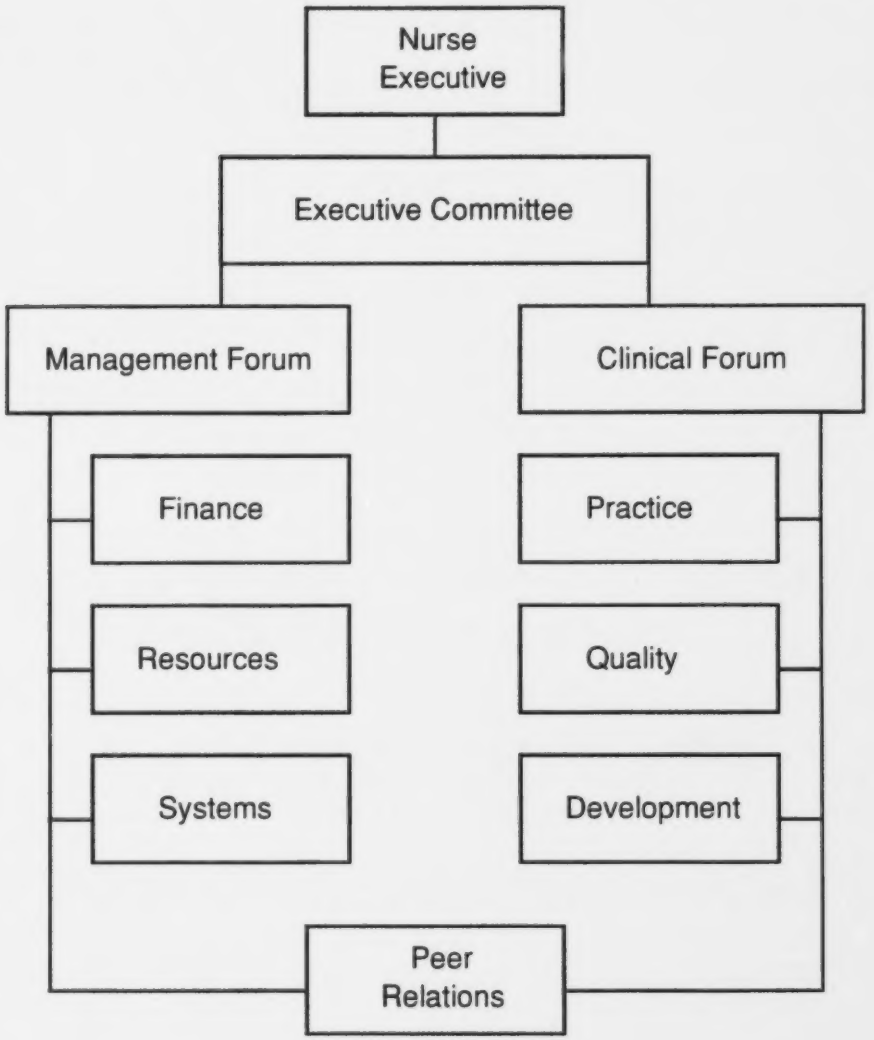
**Commonalties and Differences in Shared Governance Models**

The professional practice models addressed previously are models of accountability based governance. In writing about governance models, Porter-O'Grady (1987, p. 283) states that "authority, control, and autonomy exist in the organization based on specifically defined areas of accountability". Authority is established through processes rather than in individuals. From these processes, functions and acceptance of accountability, the professional organization forms. The organizational structure becomes the context for the governance structure. Porter-O'Grady (1987, p. 283) outlines four guidelines for building a professional governance model. They are:

1. Authority is assigned based on appropriate location, and a defined mechanism is established for determining such assignment.
2. The manager's role is to facilitate, integrate, and coordinate the system and resources required for the system's maintenance and growth.
3. The professional nurse has an obligation not only to do the work of nursing care but also to undertake those activities that ensure the ongoing operation of nursing service.
4. The nursing care system must be self-supporting and self-directed while integrating with other systems that collectively offer care services to a highly variable consumer community.

**Figure 4**

**Administrative Model of Nursing Governance**




Porter-O'Grady (1987) and Merker & Burkhart (1991)

In each of the three models, staff nurses have the majority representation; the exception is in the Councilar Model where the Management Council is made up of mainly management with staff nurse representation (Porter-O'Grady, 1987). All the models deal with the governance of primary nursing issues of practice, education, peer relations and quality. The Administrative Model has the Management Forum dealing with money issues: finance, resources, and systems and the Clinical Forum dealing with issues of professional practice: practice, quality and development.

The models vary in the degrees of autonomy for decision-making, accountability, and control. The veto power granted to the nurse executive is an outstanding difference in the Administrative Model from the Councilar and Congressional models (Porter-O'Grady, 1987; Merker & Burkhart, 1991).

**Transformation to a Shared Governance Model**

Much of the literature on planned educational change can be applied to organizational change in nursing. Porter-O'Grady (1991), has referred to this planned change process as transformation.

Porter-O'Grady (1987 & 1991), Porter-O'Grady & Finnigan (1984), Kreuger (1989) and Merker & Burkhart (1991) have all emphasized that the transformation to a professional model of nursing governance requires the establishment of written bylaws and an extensive orientation program for staff that includes group process and communication techniques. Bylaws cover issues such as: control, electoral processes, roles of accountability, veto powers, clarification of nursing values, lines of authority, and commitment by members of the organization and its governing board (Porter-O'Grady, 1989).

Porter-O'Grady (1989) has outlined guidelines that facilitate and enhance group processes and communication. They are:

1) It is important when undertaking an orientation program to begin with a literature search and a discussion of the various types of models of shared governance

that are in existence. This allows the organization to select and/or modify a model that best suits its needs and to establish ownership of the model.

2) The organization is encouraged to have the councils, cabinets or forums assume control of their areas of designated responsibility.

3) The transformation to the model should be simultaneous for both staff and management. Both embark on the process together, from the decision to undertake the adoption of a shared governance model until the transformation is complete.

4) Extensive communication is necessary to keep everyone who is involved informed.

5) In addition to orienting the nursing staff about the transformation, it is necessary to communicate with other departments regarding the transformation, what it means to the organization, and how the processes of shared governance are being implemented.

Kreuger (1989) states that by reducing personal and organization stresses, the implementation of a shared governance model will have fewer difficulties. She outlines ways to reduce the stresses. They are:

1) *Making the change understandable*. This is accomplished through the development of a model that is valued and understood by all involved.

2) *Monitoring readiness for change*. Strategies used will clarify meaning, relate the old form of organization to the new model, and discuss role changes and expectations.

3) *Reducing manager roles anxieties*. The roles and functions of management will change. Management become facilitators, partners in the process. Control for managerial and professional decisions is eliminated. Reducing the ambiguity of management roles, especially middle management, will lead to decreased

anxieties and stress. The establishment of new communication patterns will assist this process.

4) *Role of planning*. The transformation must be a carefully planned process that includes goals, the critical path, role descriptions, expected behaviors and risk taking.

5) *Challenge of shared governance*. The potential for growth is unlimited in an organization that has as its leaders, individuals who are committed, resilient, flexible, open and creative. These individuals facilitate and guide the process of transformation and reduce organizational stress.

**Resistors to the Implementation of a Shared Governance Model**

Resistors to the implementation of a shared governance model are the same resistors to change that are identified in the literature. Organizations will have difficulty changing to a model of shared governance when little attention is paid to the processes of transformation. Hibberd, Storoz & Andrews (1992) identified the barriers to the successful implementation of a selected shared governance model as: role strain and ambiguity (who has authority?, what amount of autonomy?) , environmental contingencies (economic recession, escalating health care delivery costs), nurses' union (layoffs, elimination of positions and bumpings), and organizational readjustment (recent change in the position of Vice President Nursing) . These barriers arose when a model of shared governance was imposed without adequate information regarding the concept of shared governance or the model selected, the workings of the model and the changes in roles that would be required by members of the Nursing Division upon implementation.

Kreuger (1989) states that in the early stages of implementation, the greatest resistance to a shared governance model occurs with the personal and organizational stresses that arise from implementation of the model. By reducing the stresses as outlined in the previous section, a successful transformation can occur.

Porter-O'Grady (1987) describes inhibitors to group productivity and communication, and which, when overcome, eventually lead to the successful transformation to a shared governance model. They are:

1) The imposition, by management, of a decision to implement a shared governance model without the input and support of staff. The decision to embark on a transformation should be a joint process.
2) The formation of too many committees and task forces leads to confusion. A representative steering committee should be able to guide the organization through the process to successful implementation.
3) The process takes from three to five years. It is advisable not to proceed too quickly. Decisions made in haste and with inadequate or inappropriate information, may be regretted at a future time.
4) Implement the process in all units at the same time to reduce elitism and organizational dead ends.

## Summary and Conclusions

The models of shared governance outlined that have been outlined are the processes that give nurses the authority for decisions that affect their practice, and control over the implementation of those decisions. Factors that facilitate the transformation to a shared governance model are well documented in the literature. Organizations, contemplating a change from a traditional, bureaucratic organizational model to a professional governance model, are well advised to take into account both the factors that facilitate the process and the factors that inhibit the process. It is also recommended that they read the reports in the literature of successful implementations (Chandler, 1991; Jacoby & Terpstra, 1990; Jones & Oritz, 1989; Kabb, 1990; Ludemann & Brown, 1989; McDonagh, Rhodes, Sharkey & Goodroe, 1989; Oritz, Gehring & Sovie, 1987; Pinkerton et al, 1989; Schindler, Pennack & McFolling, 1989).

In conclusion, nurses desire to move towards strong professional practice through increased autonomy, accountability, and responsibility in defining, articulating and evaluating practice. These goals are supported by the philosophy and processes of shared governance models. These processes will give nurses the authority for decisions that affect their practice, and control over the implementation and outcomes of those decisions. In doing so, nurses will be well equipped to face the challenges of health care delivery systems of the future.

# CHAPTER FOUR: METHODOLOGY

This chapter will outline the research design of the study, the criteria for sample selection, the recruitment process, data collection and analysis, trustworthiness and credibility and ethical considerations.

## Research Design

The purpose of this study was to identify and describe the perceptions of the members of the Nursing Governance Task Force (NGTF) regarding the process used to develop the University of Alberta Hospitals' C.A.R.E. (Co-operation; Accountability; Respect; Empowerment) Model of nursing governance. There is a great deal of documentation regarding Porter-O'Grady's model of nursing governance (shared governance). The literature focuses on the application of that model in large, non-unionized hospitals in the United States. The University of Alberta Hospitals is a large, unionized hospital in Canada and the NGTF developed their own model of nursing governance rather than applying a model that currently existed.

The following discussion will provide an overview of descriptive research and will address the sample selection, participant recruitment, data collection, data analysis, trustworthiness and credibility, and ethical considerations specific to conducting research in the area under study.

## Descriptive Research

A qualitative research approach, was selected to gain an understanding of the perceptions of the process and to explore how the NGTF attached meaning to events or life circumstances surrounding the development of the model (Berg, 1989). This approach was selected for study in this area because of the nature of the research question and the gaps in knowledge concerning a process for developing a model of nursing. There is little documentation in the literature of the processes such as the one undertaken by the NGTF. This topic had not previously been explored, and the participants had had personal

experience with the process. Interviewing was selected as the method of collecting the data providing an understanding to the process (Fontana & Frey in Denzin & Lincoln, 1994).

### Criteria for Sample Selection

The main criterion for the sample selection was that the study participants had all been members of the NGTF. The sample was less than twenty-five and was a target population All ten participants in the study were members of the NGTF. The NGTF consisted of representatives from all levels of the Nursing Division in the University of Alberta Hospitals, management, staff nurses and unions officials. The membership of the Task Force fluctuated during the two years of its existence. A core group of twelve members remained constant throughout this period. One member of the core group moved out of the province following the development of the C.A.R.E. Model and subsequently was not interviewed; one member of the core group, representing the nurse educators, was the principal investigator of this study. All ten remaining members of the core group of the Task Force consented to participate.

### Participant Recruitment

To conduct this study and gain access to the members of the NGTF, ethical approval was obtained from the Department of Educational Administration Research Ethics Review Committee, the Faculty of Nursing, University of Alberta and Division of Nursing, University of Alberta Hospitals' Joint Ethics Review Committee, the University of Alberta Hospitals Board Special Services and Research Committee. Letters of support for the study were obtained from the Vice-President Nursing and the C.A.R.E. Model Evaluation Task Force. These letters of support accompanied the proposal to the University of Alberta Hospitals Board Special Services and Research Committee. All ethics review committees supported this research proposal.

Letters were sent to the ten members of the NGTF soliciting their participation in the study (see Appendix E). Through follow-up telephone calls to all the members an explanation of the purpose of the study and their involvement was given. If they agreed to

participate in the study a convenient date, time, and venue for conducting the interviews was arranged. All ten members of the Task Force had received information from the researcher regarding the study, and had read and signed the consent form (see Appendix F).

## Data Collection

The data were collected through taped, semi-structured interviews (see Appendix G). In addition, information minutes of the Nursing Council and the NGTF were added as additional data.

### Procedures

At the time and place established for the interview appointment, a verbal description of the research study was given to all of the participants. All of the participants were informed of their right to withhold answers to any question. Any questions posed by the participants regarding the study were answered.

The interviews were transcribed and a copy was sent, with an accompanying letter (see Appendix H) to the participants. This provided them with the opportunity to verify the information, and the opportunity to delete comments or add additional relevant ideas.

### The Instrument

The instrument used was a series of fourteen semi-structured, researcher-designed questions that were asked by the researcher during a taped interview (see Appendix G). The demographic data were collected to determine if further graduate education, which may have included theory on organizational change and management styles, influenced the participants perceptions of the process. Shared governance is a form of decentralized decision-making, and therefore data on the Task Forces' method of making decisions were collected. Questions on motivation were included to determine if there was a commitment to the process of development of a model of shared governance. The is a lack of literature describing the process of developing a model of shared governance in large, Canadian, unionized hospitals, and it was hoped that a process could be described by eliciting the

perceptions of the Task Force regarding the factors that facilitated and hindered the process that had been employed in the development of the C.A.R.E. Model. Open-ended questions were used to elicit the information being studied.

The questions had been used in one pilot interview with a member of the University of Alberta Hospitals' School of Nursing Committee on Committees (2C). The 2C was concurrently working on developing a model of governance for the School of Nursing. The pilot interview allowed the researcher to assess the following: 1) the questions, 2) the researcher's interviewing skills, and 3) the researcher's comfort with the mechanics of a recorded interview process. No changes were made in either the interview format or the questions.

## Data Analysis

Interview tapes were reviewed and transcribed verbatim by the researcher following each interview. All identifiers were removed from the transcripts and a pseudonym assigned. The data were sorted and grouped into categories that included demographics, motivation for joining and remaining on the Task Force, recollections of the process used to develop the C.A.R.E. Model of Nursing Governance, facilitators to the process, hindrances to the process, and overall perceptions of the process. Content analysis was undertaken to identify patterns and recurring themes. Topic areas were grouped under similar headings. Once grouped, they were labelled and complied into a document. The documents were examined and this examination lead to the emergence of themes.

## Trustworthiness and Credibility

The issue of objectivity must be laid out in the qualitative research design, in order to acknowledge and attempt to minimize the effects of the researcher's values, biases and preconceptions (Brink and Wood, 1989). "The researcher makes every effort to clear his or her perceptual field so that he or she can absorb experience as fresh, new and unbiased" (Brink and Wood, 1989, p. 176). The researcher acknowledges that she was not only a part of the process of developing the C.A.R.E. Model of Nursing Governance, but also an

advocate of shared governance as a means to defining professional nursing practice. The researcher reassured the participants that the sources of all data that were collected would remain confidential and that the results of the study would not place the participants at risk within the organization. Collecting the data after the implementation of the model and the subsequent halting of the implementation of the model, allowed the researcher to be less involved with the process and more objective (Morse in Denzin & Lincoln, 1994). To maintain objectivity during the study, the amount of prompting by the researcher was kept at a minimum in an attempt to avoid influencing the responses of the participants.

The data that were collected consisted of personal recollections of the members of the NGTF and were collected one year after the NGTF completed its task. The members of NGTF not have notes or minutes available during the interviews.

The researcher, having been a member of the NGTF since its beginnings, was familiar to all the members who agreed to participate in the study. The data that were collected was assumed to be sincere and valid as a result of the participants' existing positive relationships with the researcher.

The researcher was cognizant of researcher bias throughout the process of this study. The researcher was known to many of the members of the Task Force prior to its inception. During the process of the development of the C.A.R.E. Model of Nursing Governance, the researcher had developed positive relationships with the members of the Task Force that participated in this study. The researcher was an advocate of shared governance, as well as the change process. Throughout this study, every attempt was made by the researcher to reduce and minimize bias. The participants were contacted once by letter and then a follow-up phone call. Contact with them prior to the interview was kept to a minimum to reduce or eliminate any feelings of coercion.

The semi-structured questions used during the interviews were designed to provide an opening for discussion. The questions provided some direction for the discussion but were open-ended to allow for a free-flow of ideas. During the interviews, prompting and

answering of questions by the researcher was kept to a minimum. Clarification was requested through the use of close-ended questions. To ensure that the participants had the opportunity to clarify, revise, add or delete the content of the interviews, they were given the opportunity to review and edit the transcripts. They were also offered the opportunity for an additional interview with the researcher. All participants responded by reviewing and editing their transcripts; no participant requested an additional interview.

During analysis of the data, the researcher used only the transcribed data as a source of information. The tapes were not used as an attempt to reduce bias which might arise from inflections and tone of the recorded voice. Body language was neither noted nor recorded for the same reasons.

## Ethical Considerations

The researcher was not conducting this study as part of her current position with the University of Alberta Hospitals, but as part of the requirements for a graduate degree. Members freely consented to participate in the study. The members consented or refused to participate without placing their positions within the Hospitals in jeopardy.

The rights of the participants were protected in several ways. A written explanation of the nature of the study and the participant's role in the study was included in the initial contact letter (see Appendix E). Participation in the study was completely voluntary. During the course of obtaining consent (see Appendix F), the subjects were given the option to withdraw from the study at any time by verbally indicating their intention. The participants were advised that the interviews would be transcribed and in an attempt to maintain confidentiality, they would be given a pseudonym. Participants would be given the opportunity to review the transcribed interviews to verify the information, and the opportunity to delete comments or add additional relevant ideas (see Appendix H). Due to the small sample size of ten NGTF members, it was not possible to assure the participants of complete anonymity, but individuals' comments were not identifiable to their position within the Hospitals.. Participants were aware that the results of this study may be used in

writings for publication. The hospital will be identified in the study, the thesis and written publications.

# CHAPTER FIVE: FINDINGS

The findings outlined in this chapter have been grouped under six major categories which were derived from the topic areas that were discussed in the interviews. The major categories are: characteristics of the participants, motivation, participants' description of the process, decision-making within the process, facilitating factors and hindering factors. Subcategories emerged from the major categories. Each category and subcategory is presented with a brief descriptions and followed by direct quotations from the transcripts of the interviews. Any response that related to the category was reported, as it was deemed by the researcher to be important and significant to the participant.

## Characteristics of the Participants

The participants were asked to describe the length of time that they had been employed at the University of Alberta Hospitals, and the position that they currently held within the organization. They were also asked about their educational background and their reasons for joining the Nursing Governance Task Force (NGTF).

The ten participants in the study had been employed by the University of Alberta Hospitals' (UAH) Nursing Division between four and twenty-two years. They included the Vice-President of Nursing (VPN), a Director of Nursing (DON), a Nurse Manager, an administrative support person, a Clinical Supervisor, the Staff Nurses Association of Alberta (SNAA) Local I President, the Canadian Health Care Guild (CHCG) UAH Local President, and four staff nurses. The Nurse Educators were represented on the Task Force but their views were not reflected in this study as the representative of the Nurse Educators was the researcher. The participants were employed in a broad cross-section of areas within the Nursing Division. These areas included surgical, intensive care, medical, emergency and psychiatric areas of the Hospitals. No part of the Nursing Division was excluded in this process. These areas ranged from speciality areas such as Intensive Care Units and the Operating Room to general medical and surgical units.

There were ten participants in the study. Six Registered Nurses were diploma graduates from three year hospital-based programs. Two of the six diploma graduates were currently enrolled in a post-basic baccalaureate degree (one in Nursing and the other in Business Administration). Of the remaining four diploma graduates, one had a post-basic baccalaureate degree, one had a masters degree, one had a doctoral degree, and one had chosen not to persue further education at the present. The other two Registered Nurses on the Task Force received their basic nursing education from university baccalaureate degree programs. The remaining two participants on the Task Force were not nurses, but were members of the nursing division. One was an administrative support person and the other was a Licensed Practical Nurse (LPN). All three of Registered Nurses who represented management on the NGTF had graduate education. Two of the diploma graduates and two of the baccalaureate graduates had a variety of post-diploma certificates.

All the staff nurses had volunteered to be members of the NGTF. The Vice-President of Nursing, the administrative support person, Staff Nurses Association of Alberta Local I President, and the Canadian Health Care Guild UAH Local President were on the Task Force as a result of their positions. When the original Director of Nursing had to withdraw for personal reasons, she was replaced by a second Director. The Director of Nursing who was interviewed had been on the original Nursing Council and strongly supported the concept of nursing governance. The Nurse Managers group was not represented on NGTF when it was initially formed. They requested to have representation on the Task Force and they recruited a representative from their group. The Nurse Manager representative attended the initial meeting. The felt that they were important stakeholders in the process of shared governance because they were going to be the group that facilitated the functioning of the decentralized councils. As a result they felt that it was necessary for them to be involved with the process of the development of the model from the beginning.

## Motivation to Join the Nursing Governance Task Force

Participants were asked the reasons that they joined the NGTF. They joined the NGTF for three reasons: 1) volunteering individually, 2) volunteering as a representative of a particular stakeholder group, and 3) representation by virtue of their position (hospital management, administrative support or union representation). Whether they had joined by volunteering or by representing a specific stakeholder group, they were all willing to discuss change and how it was going to affect them both personally and professionally.

### Individual Volunteering

The three individuals who volunteered were all staff nurses. Their motivation to join was that they viewed this as an opportunity to become involved in the development of a nursing governance model and have an impact on the changes that would affect their direct nursing care. One participant who volunteered offered the following comment:

> I saw it as an opportunity for staff nurses to become involved in the governance structure of the Hospitals within the Nursing Division at the time (Eta).

A second participant had viewed the friction between management and staff during four provincial nursing strikes and felt that the friction could be reduced if nursing management and staff could work together on a governance model.

> I read the information that was posted on the bulletin board. It was something that I had been interested in. I've always felt that if nursing management and nursing staff got together, we would be far, far more effective. I saw this through four strikes in which I was involved in and what happened here at UAH. And it was the result of management and employees not being able to come to any consensus. This was the first hope that I had seen over all the years. I was very interested.(Kappa)

A third participant was urged to join the Task Force by a mentor.

> There were all kinds of messages in the mail, on computer mail, saying what this Task Force was going to be doing. They were searching for new members, since there had been some fallout of members from the original group. A mentor of mine send me a computer mail message, thinking I would be an asset to the Task Force. She was currently on the Nursing Council. She basically "bothered" me until I went. At the first meeting that I went to find out what it was all about, I realized what a great impact it was going to have on my direct nursing care. If more staff nurses weren't involved in the development of the governance model, we were going to have to "eat" this anyway, so we might as well be involved from the beginning. (Theta).

**Representative of a Stakeholder Group**

Three members volunteered as members of a particular stakeholder group. One participant was "talked" into joining the NGTF and initially displayed no interest in the project.

> Actually, I was talked into it. It was sort of an afterthought. The group I represented wanted some representation. At one of our meetings, in which there was a very small attendance, (there was about ten of us there), they asked if anyone was interested. No one was. No one really knew anything about it the shared Governance Task Force at the time. I was talked into it. I didn't have any interest in it. (Iota).

The other two participant volunteered to represent their respective groups for different reasons. One felt that there was limited experience with and knowledge about nursing governance within the Hospitals and viewed this as an opportunity to gain both personal knowledge and experience.

> I volunteered because we had a new Vice-President of Nursing and shared governance was being talked about an awful lot, but the majority of people

> in my experience really didn't know what shared governance was, and really didn't understand, including me, what the implications were going to be. It seemed like it needed quite a bit of work. I was an individual volunteering as a request from a group. There was a request for a member of [my group] to go on the Task Force and I volunteered. I have no idea if there were other people from my group who volunteered as well. (Delta)

The other volunteer member replaced a member of the Task Force who had to resign for personal reasons. The replacement member was eager to represent her group on the Task Force.

> I had been on Nursing Council from the time that it was formed. I strongly supported the formation of a task force to develop the governance model, because I had seen it go wrong, and I knew that shared governance had a lot of potential. I knew it could be done right and I though the way to do it was to have a separate committee developing it, which was the route we took. I wasn't upset that I wasn't on the committee to start off with. However, when the opportunity arose, when a member of a representative group became ill for an extended period of time, I was quite pleased to be asked if I was interested in sitting on the committee. I think it stems back to my innate belief that nurses are empowered but they just need to recognize it. It was what nursing needed. I really believed in the concept of nursing governance, and that is why I wanted to be on the committee. (Lambda)

**Representation by Virtue of Position**

The four remaining participants joined the Task Force by virtue of their positions within the Hospitals or the Unions, the Staff Nurses Association of Alberta (SNAA) and the Canadian Health Care Guild (CHCG). The SNAA represented all nurses at the UAH, both within the Nursing Division and external to the Nursing Division. When this process began, SNAA was committed to the task, against the wishes of a national nurses union. SNAA withdrew their support abruptly following a second round of layoffs in the fall of 1992. The CHCG represented personnel in the Nursing Division other than Registered

Nurses (eg. Licensed Practical Nurses, Nursing Aides, Nursing Attendants and Orthopedic Technicians).

In addition, they expressed personal reasons to support their membership on the NGTF. These reasons varied from the belief that they had something to offer to the Task Force, to a commitment to developing a new governance structure, to the belief that a structure was needed to formalize the philosophy of empowerment and decentralized decision making within the Hospitals.

> I found myself in the position of actually orchestrating the development of the governance structure, so I was involved by virtue of my position and was responsible for getting a governance structure up and running within the Hospitals. that we very much needed a structure to formalize that philosophy and that it just wouldn't happen unless there was a specific structure in place to ensure that it happened, so it was my commitment to the principles of the organization. (Beta)

> It started out that I was a member by virtue of my position and it continued that way. When the job first started out, I looked at it as part of my duties, and so on, but after awhile I looked forward to the meetings. I found them to be interesting and stimulating; I enjoyed being in on the ground floor and seeing how things were progressing and how it all fit together with what I knew of the rest of the Nursing Division. Once in awhile my input was solicited to gain a different perspective. The committee members included me in conversations and in the meetings, so that I did feel that I participated in some way. (Gamma)

> It was part of my role with the union. In addition to that, I had been a part of the previous nursing governance structure and its struggles and subsequent failure. I was committed to building a new structure that was going to survive in our organization. (Epsilon)

> I was a union official and I was asked to sit in the Task Force. I felt that I had something to offer the program. (Zeta)

**Motivation to Continue on the Task Force**

Participants were motivated to remain on the Task Force for a variety of reasons. All members found the experience personally rewarding. Two of the participants felt that there was potential for personal and professional growth from the process.

> I was fairly excited about the opportunities that it presented for the nursing staff and for the Nursing Division as a whole. There was a growing opportunity for change; an opportunity for a change in direction. I felt that it was a healthy way to go. (Eta)

> I liked the fact that we were all making decisions and doing it together. I found it very exciting to be using all kinds of processes. I felt that we were allowed to make some decisions and really get some work done. I hadn't felt that before. That's what motivated me to stay. For me it was definitely a good experience. (Iota)

One participant found the process itself to be motivational.

> I don't think there was ever a question of not continuing on it the Task Force, because it was something we were building ourselves. I guess it was just motivational. The whole process was motivational. (Epsilon)

Another participant chose to remain on the Task Force and be involved in the changes which were going to affect the working lives of nurses.

> It was the reality that, if any thing was going to happen in my life, I would rather have control of it, or at least the knowledge of it, before it's going to happen. This was something that was definitely going to happen and the more that I could be involved to make this work, the better I felt. (Theta)

Two participants felt that were motivated to remain on the Task Force because they had something to offer to the process.

> I felt that I had something to offer the program. (Zeta)

> I was very frightened at first because I realized that I was in a way, way over my head. The first time that I realized that maybe I had anything to contribute, was when upper management and other members of the committee, not the staff nurses, were discussing issues that would have a big impact on staff nurses. When the staff nurses said, "No, that won't work", management immediately dropped it and we approached it from another aspect. It was then that I realized that the concepts of shared governance and the development of it, could be done by the more experienced people and the educated, those that had been educated along those lines, but the staff nurses (and I was a staff nurse), could tell them if it would work or not. That's where I felt that I could contribute. It was also strictly selfish when I realized that I could learn a lot working with the Task Force. (Kappa)

Another participants found the personal growth in others a motivational force.

> My belief in the concept of shared governance motivated me to remain on the Task Force. I also think seeing the growth of individuals on the Task Force was really exciting. Seeing nurses that I had known for a number of years, and remembering the "little boxes" they used to sit in, and I saw them just blooming. (Lambda)

The remaining three participants made no comments regarding motivation.

### Decision Making within the Task Force

At the first meeting of NGTF, the issue of how the NGTF would make decisions arose and the members briefly discussed various decision- making processes. They decided that consensus would be the method used for decision-making within the group. They determined that consensus the preferred method of decision-making to voting. They felt that decision-making by consensus was compatible with the concept of shared governance. The group did not specifically define consensus at that time.

Eight of the ten participants felt that a form of consensus was used throughout the process. They agreed that it took time and trust to develop that process.

> I think it was really consensus building as we explored various issues together and as the framework that evolved in the discussion among the group. (Beta)

> Sometimes it was very labored. But most of the time it was based on ... a kind of consensus basis and "we will reach a consensus and if somebody has very strong objections to one thing or another, we will try and work through those, so that [no one] would come away feeling that they're outnumbered or a decision was made that they couldn't live with". (Gamma)

> For the most part, I remember it being consensus. We hammered through an awful lot of issues in which we reached consensus on the majority of those. (Epsilon)

> It was by group consensus, group agreement; everybody was in agreement with what had been decided. (Eta)

> It was a shared process. We agreed that we would reach decisions by consensus. (Iota)

> I'd say it was a lot of consensus. There was a lot of talking. There was never one clear person who made decisions. We had rotating facilitators. The facilitators didn't have a dictator type of relationship with the group. We all gave our opinions. The thing that I valued most about the Task Force was that your opinions were valued. Even if you disagreed, you were still valued. You weren't attacked in any way. It was "Okay, let's see what we can do to accommodate that". It just always worked out until the right decision that everybody was happy with was reached. There was only one decision that I can recall where one person never really got her decision incorporated. (Theta)

> We had free and open discussions. I think people seemed to feel comfortable and really free to say that they agreed or disagreed with a particular point That probably took time and trust, but it impressed me that people seemed to be able to do that. (Lambda)

Two participants expressed concerns regarding the consensus building process. One expressed concern that all members were not totally committed to the process of consensus.

> I'd love to say we made decisions by consensus. I think some of them we made by consensus. But I think, as with any group, there were perceptions of who should or shouldn't be speaking at any particular time or who should or shouldn't be making a decision. There were times when I though we had made a group decision and it got changed afterwards. I can't remember specifics, but I can remember it happening and thinking "I thought we decided on that already". Part of the problem was that the group didn't know what consensus was] We had some members who were quieter than others; some members who probably left the room and then said what they wanted to say. They got better as time went on. We also had some changes in the committee as time went on. (Lambda)

The other expressed concern about the weighting of membership (management versus nonmanagement) on the Task Force.

> Decision making was by consensus. I think that was a good idea, but if you look at the weighting of the committee and the realistic situation that was going to be in effect with shared governance, what was the consensus decision of the Task Force, may not have been going to work very well in reality. I think that the weighting of that committee, given the fact that not all of the administrative people were at the meetings at the same time, led to some difficulties. The SNAA was also present and looking after union interests as opposed to nursing interests. (Delta)

## Factors that Facilitated the Process

Factors that facilitated the process of developing the C.A.R.E. (Co-operation; Accountability; Respect; Empowerment) Model of nursing governance were grouped into three broad categories. All the factors that the participants identified have been included in these findings. The factors have been identified as: 1) the positive attitudes of Task Force members which includes the composition of the Task Force and the environment within the Task Force; 2) resources which includes availability of funds, the use of resource people, participation in the University of Alberta Hospitals'Quality Improvement (UAH QI) Programs, and the use of the QI "Tools and Techniques"; 3) time elements which include staff scheduling and peer support, and the flexibility to negotiate alteration in the "critical path". No one of these factors was noted to be of more importance than the other two. All three factors were critical to facilitate the process.

### Positive Attitudes and Environment

Seven of the participants felt that the positive attitude and environment within the Task Force was one of the greatest facilitating factors. The positive attitude was expressed through the following comments on motivation, enthusiasm, commitment, openness, honesty, friendliness, and equality.

> I think the willingness of everybody to recognize that something needed to be developed; that we had to move on from where we had been. Nobody wanted to live with the confusion that they had been in any longer. (Delta)

> The group worked well together. There was non-commitment on all parties to built it and make something that was going to be workable in our place of work. (Epsilon)

> I didn't feel that I had to say certain things to impress administration or anyone. I could talk openly and honestly about what I felt. (Eta)

Somehow everybody, once they came into that room, was stripped of authority. It didn't seem that anyone in the group was any less or more important that anyone else That certainly helped. I was a staff nurse sitting beside the Vice-President of Nursing, two Directors of Nursing, a Nurse Manager, a Nurse Educator, and union local presidents. It seemed to be a group of very "higher-up big-wig" and yet we were all equal. There were no personalities or attitudes in the room. We were all a group of friends with a task to accomplish, at least that is how it seemed to me. (Theta)

Everyone was very committed and I'm sure it was difficult for everyone to be so committed, especially the nurses who did work shiftwork. A lot of them, including myself would come in after working nights. I feel there was definitely a strong commitment there by each of us. In the beginning it was tough, and I'm sure everyone felt this way, you're not really sure what it is that you are doing. You're almost afraid to voice something, because you're not even sure why you are there, or what it is that you are trying to achieve. In the beginning, it might have been more difficult but by the and, no not even by the end, but somewhere along the way, I felt comfortable. (Iota)

Everybody was on an equal basis, a professional basis. This was something shared governance that would benefit us all. I went in there with "rose -colored glasses' and I really was hoping that this would be a friendly environment. And that was actually the atmosphere that I felt was there. (Kappa)

I'm quite sure that everybody on the committee was there because they wanted to be. They would have been motivated in the beginning which probably facilitated the process The enthusiasm of the majority of members of the committee was infectious. The more people began to communicate with people outside the committee and get some positive feedback, that gave them some enthusiasm. (Lambda)

Seven participants commented about the cross-sectional makeup of the Task Force and how the composition of the group facilitated the process. The Task Force was made

up of members who represented a cross section of the Nursing Division. This was a vertical representation from administration to middle management to staff nurses. Administration was represented by the Vice-President of Nursing, a Director of Nursing, and a Nurse Manager. Staff nurses were represented by a Clinical Supervisor, a Nurse Educator (the researcher), up to seven staff nurses (although only three were consistent members and participated in the study). The inconsistent membership of the staff nurses placed the burden of the work done by the staff nurses on the shoulders of the three consistent members. The NGTF was also continually faced with reorientating new members to the group and this involved time and the efforts of the core members of the group. The Staff Nurses Association of Alberta represented the interests of staff nurses, and the Canadian Health Care Guild represented the interests of Licensed Practical Nurses (LPNs), Orthopedic Technicians and Aides. One member of the committee was appointed as administrative (secretarial) support. During the process of the development of the Model, the administrative support was acknowledged by the NGTF to be a valued member of the group.

The comments from the participants are as follows:

> A wide variety of involvement was very helpful. I think it was important to have the senior executive involved in the group; I think it was important to have the union representation; and the involvement of all the people that were there, including LPN representation. All of this contributed to the legitimacy of the project and the manner that it was accepted for implementation (Beta).

> There certainly was a broad representation of people/staff. I cannot think of anyone that was missed from that group. It was a good representation. There was management; there were staff nurses. The people that were involved around the table were the stakeholders; a good cross section of nurses that would be working with this on a daily basis (Epsilon).

We had to allow new people to come onto the committee. It was such a growing project. Having new ideas was helpful in developing the model. The continuous influx of new ideas and members was actually a facilitator to the process (Eta).

Membership was pretty well-rounded (Zeta).

Everybody brought to the group different ideas and different ways of doing things. I think it definitely helped to have a Director and the Vice-President of Nursing on the Task Force, because they had a more general overview as to how things were going in the entire institution and in the Nursing Division. We brought special qualities from each of the divisions, or each of the different areas that we represented. There was good representation at every meeting. (Iota)

I liked the concept of having a cross section of all levels of nursing. (Kappa)

We had people from the unions, administration, staff nurses and education. Having a cross section from all those groups was really beneficial. We could understand each other and where we were coming from. (Lambda)

The environment within the Task Force was developed from the positive attitudes of the group members. It has been described as being open, free, friendly and non-threatening by six participants.

I think that this was a very inductive process. (Beta)

I sat in on the Task Force at the beginning with my immediate supervisor. And from my point of view, I didn't feel threatened. I didn't feel that I had to say certain things to impress administration or anyone. I could talk openly and honestly. (Eta)

> I don't think that you would have had as much freedom of speech if that environment hadn't existed. (Theta)

> When I voiced my opinions they were listened to by members of the group; I felt free to voice my opinions. (Iota)

> People felt free and easy to speak their mind. (Lambda)

> I felt that it was a very friendly environment. Everybody was on an equal basis, a professional basis. It was not a threatening environment at all; it was a challenging one. My opinions were valued. (Kappa)

**Resources**

Four participants felt that the availability of Job Enhancement Funds definitely facilitated the process as they allowed for relief dollars to allow members of the NGTF to attend meetings.

> We had an enabling grant from the Job Enhancement Fund that enabled us to provide relief for people, away from their jobs if they needed to be replaced. It was very important. (Beta)

> If the Job Enhancement funds had been there in the beginning, there might have been an easier time for people to get time off. Because when you work shift, when you're on the night shift, it's pretty hard to come in for a meeting early in the morning, unless you had the time off or could rearrange your shift. (Eta)

> ...working in a different environment where they never have a quiet time, I certainly see how it would impair attendance at any meeting. If there was no funding to go, to replace yourself on the unit, then it's impossible. (Theta)

> I know it was one of the decisions that we had to wrestle with, because you would like to think that something like this was actually part of your job and therefore you wouldn't need to get extra pay. But the reality is that when

> you work shift, you are trying to cover looking after patients as well as being the representative for your unit at the meetings. When you work nights, you're going to have to come in on a day off to make this work. It was important to compensate people for their time somehow. I don't think we found the answer. I think Job Enhancement funds are necessary for anything like this to work. People can only put in so much of their own time. (Lambda)

Resource people to facilitate the process and to provide background information of models of nursing governance was identified by three participants as a facilitating factor.

> ...certainly the QI Department was helpful as we were utilizing QI techniques and processes. (Epsilon)

> We did bring resource people in. One from a union who brought a perspective from an American hospital. We had QI facilitators come in and help us with processes that we weren't all familiar with. The facilitator worked as a member of the committee, but she also functioned as a resource person to give a broad perspective. At that time a lot of decisions were made in the corporate level and she gave us some insight to that and how it might be changed. (Gamma)

> I felt that the facilitator, the leader, as a facilitator was good. (Kappa)

Seven participants expressed opinions about the Task Force's participation in the UAH QI Program (ACHIEVE); at least having taken the initial program, Group Action[5], which included.content on group action skills such as group process, facilitating successful meetings, and problem-solving as a group.

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[5] Group Action is a program within the University of Alberta Hospitals' Quality Improvement Program ACHIEVE.

The QI processes helped because they removed some of the emotional barriers to people saying "this is the way I...". Most of the people on the Task Force were very enthusiastic and wanted to move forward. When we hit an obstacle, bringing in the tools and techniques form the QI Program made things more objective and we were able to move on. (Gamma)
We were dealing with a lot of different people who had come together and who had to come out of the process with a model in place. I don't think the majority of people who were on the committee were used to to working with models. Nor were they used to expressing themselves unless they were comfortable. There was a lot of differences in people on the committee. I think that it was probably facilitated by the ACHIEVE courses that the members of the committee participated in. Everybody was approximately at the same level when it came to expressing themselves. (Delta)

Thinking of the scope of the ACHIEVE programs and some of the basic principals that ACHIEVE teaches you, probably helped [the process]. (Epsilon)

It was helpful for the problem solving and the decision making. Once I took the course I was better able to understand the process that we were going through. (Eta)

If there had been perhaps a little bit more of a learning experience to the Task Force and putting people on the same basic level, I would have been more comfortable. There was certainly an equal base with a QI program under their belt. (Theta)

Having been through some of the QI Programs definitely made the process go easier. I found there was a lot of wording that was totally foreign and seemed to be flowing quite frequently through the meetings that didn't mean anything initially. (Zeta)

I definitely feel that it would have been helpful if everybody had started out at the same level, having been through the QI Programs, prior to starting this process. (Kappa)

Two participants felt that it was more beneficial to the process to be at different levels within the ACHIEVE programs. Some of the participants had progressed through the various levels of the program and were acting as facilitators to other groups taking the program. Others had either just begun the take the entry level program, Group Action, or had just completed Group Action. And others had not begun the program.

> The fact that people were thinking on different levels and involved probably facilitated the process. (Epsilon)

> It might have been helpful, but I think that it was a growing process for all of us at the time. (Eta)

Three participants felt that use of the "Tools and Techniques" of the Quality Improvement (QI) Program ACHIEVE were a facilitating factor. These "Tools and Techniques" are small group work, brainstorming, "silent sorting", "fish boning", and setting of group goals for each meeting. This was expressed through the following comments:

> The tools that were used in the QI Program were very much an inductive method of trying to understand the direction that you need to be taking. (Beta)

> The tools and techniques that are an inherent part of the QI Program were beneficial to this process. (Delta)

> Those activities, the "silent sorting", the brainstorming, and the "fish boning", were probably factors in the process. (Epsilon)

**Timing**

The Job Enhancement Funds were not available at the beginning of this process. Many of the staff nurses struggled to attend meetings. Having the funds available for relief

was only one part of the complex puzzle which allowed members of the NGTF to attend meetings on a regular basis. As the funds were temporary, some units chose to use funds to provide relief for the staff nurse to attend meetings; other units chose not to utilize the funds by covering for the representative internally. Staff scheduling and peer support on the units for the representative was important. It either facilitated or hindered the process, depending on the units and their individual situations.

> Staff scheduling and peer support, or peer willingness to cover for you while you attended a meeting, could either help or hinder the process depending on the individuals' situation. I think that is an ongoing problem in nursing as far as staff nurses go. (Eta)

> The units have to work this through on their own basis to support the member that was going to sit on the Task Force. Working in an environment where they never have a quiet time, I can see how it would impair attendance at any meeting. I'm now being asked to sit on another committee similar to the Professional Council and I can't. There is no funding to go. In other words, if you don't have funding, you have to have a commitment by the unit to free you up to go. (Theta)

> Some departments were very, very supportive. Commitment was not only by the member but by the departments as well. Some units had extra staff or were able to bring staff in to cover. Others had to believe in the process and buy into what was going on at that point. It was perhaps hard for people to say "Yes this is a necessary thing to have somebody participate in". (Zeta)

One participant felt that having the flexibility to negotiate alterations in the time line made the process easier.

> I think the time frame that we were working with was being altered. They gave us a little bit more time. I think at some point the process seemed to

> bog down within the time limit for what we were going to do and I think that changing the time limit loosened that up. I was having a hard time ingesting a lot of what was going on. It was going very quickly. (Zeta)

## Hindering Factors

The factors that hindered the process have been identified as: 1) attitudes of members, the nurse manager group and staff; 2) fluctuating membership which included the inconsistent attendance at meetings; 3) time constraints which included the scheduling of meetings, the time spent revising the philosophy and time allotted to the NGTF to complete the task, and 4) the role of the facilitator who was the Vice-President Nursing and had a vested interest in the process. No one of these factors was deemed to be of more importance than the other three. The presence of any one of the hindering factors could pose difficulty with the process. All the factors that the participants identified have been included in these findings.

### Attitudes

Four participants felt that the negative attitudes of the group members may have hindered the process. They have identified these attitudes as 1) an unwillingness to admit that there were difficulties, 2) a reluctance to change, 3) mistrust of management, and 4) pre-expectations such as the types of decisions that staff nurses would be making.

> ...we really perhaps were too gentle when it came to explaining things to staff nurses that were on the committee. I think we needed to say, "Okay, we recognized that this may cause a problem We recognize that there is a contract to be observed. These are the kinds of issues we see coming out of this". It was felt that we should develop a model and try and then deal with the problems, if there were going to be problems afterwards. I don't think there was a willingness to admit that there was going to be problems. (Delta)

> ...there were a couple of people who appeared to not be quite as open to changing the paradigms and changing the thoughts on how decisions would be made. Some people were sticking to the old ways of "This is the way we'd still like to do it. Even though you guys want to move forward, I'd still like to stick to the old ways". (Gamma)

> I suppose with anything new, people are reluctant to change. I guess it was a process of actually buying into the end product. I think that some of them truly didn't believe that management were going to give them the free reign that they were talking about decision-making. (Zeta)

> ...people went with totally different perceptions of what this was all about (that staff nurses, including the union, would be making all the decisions for the Nursing Division); that stood in the way. We spent a lot of meetings getting caught up in that and rehashing something we had talked about the week before. (Lambda)

Two participants felt that the attitudes of the Nurse Manager group hindered the process. The Nurse Managers had been identified as a crucial part of the model as they had been designated as the facilitators of the decentralized councils. One participant felt:

> ...the Nurse Managers were the most non-supportive group and maybe we were the most non-supportive of them. That was the one failure I think we had. They were in a very threatened position. Their positions had been eliminated and they had no supportive union to back them up. (Kappa)

The other participant felt that the Nurse Managers were caught between the staff nurse having power and authority and the decentralization of decision-making process, and yet the Nurse Managers would continue to be accountable for the decisions that the decentralized councils would make.

> I don't think they were even caught in between. I think that it was basically swept under the carpet. I don't think there was enough inclusion at the manager level despite the fact that at the time, the decision making was being quite decentralized out from the DONs to the manager level and I think there wasn't enough account being taken of that. (Delta)

One participant felt that the attitude of the staff in the Hospitals' Nursing Division, hindered the process.

> ...perhaps the general population's resistance to it shared governance. I think that it was new and it had been tried before in a small way. A lot of people weren't very receptive to it and weren't at all interested in hearing about it. A lot of collegial pressure made me not sure if I was doing the right thing; it had an effect. (Iota)

Another participant felt that the NGTF waited too long to communicate with the staff and as a result the staff felt a lack of ownership. This reflected back on the Task Force and hindered the process.

> I think we waited too long to get the majority of staff involved with what was happening. Although we had the newsletters, I don't know how many people read them, so maybe we should have done some different things when communicating to staff on a regular basis further back than we did. I think the committee felt real ownership for the model, but I don't think the staff felt real ownership. (Lambda)

**Fluctuating Membership**

Five participants felt that the fluctuating or inconsistent membership, and the lack of skills necessary for the task hindered the process as indicated by their comments.

> The staff nurse component of the committee changed quite a lot in the first stage. The kind of skills and the consistency wasn't there at the staff nurse

level and I think that was probably a problem. If they were only there for a couple of meetings, then by the time they were getting to know what you were actually about, you'd lost it because they weren't coming back again.(Delta)

I think it may have affected it the process in the fact that we didn't have a continuous group that knew from meeting to meeting what was going on. (Eta)

In the beginning there was quite a large group; towards the end there was only seven or eight of the key personnel that would always attend. The people that dropped out, I think, weren't necessarily committed. (Theta)

The inconsistency and changing membership of the group hindered the process. (Kappa)

The changing membership hindered the process. (Lambda)

Four participants felt that the inconsistent attendance by members at meetings hindered the process.

I guess if there is one factor that I would identify as causing problems, it is that not all members were in attendance at all meetings. In reflection, and understanding some of the problems that we're encountering now, I have the feeling that some of them are related to the fact that certain members weren't in attendance when particular decisions were made. (Beta)

There were quite a few meetings where attendance was a problem. You certainly felt the gap if they weren't there. (Theta)

Number one, the inconsistency of members to attend. (Kappa)

I think the shiftwork interfered with the ability of some people to be there on a consistent basis. And if you weren't able to be there because you were

> working nights or on a day off, you would miss the whole chunk. (Lambda)

**Time Constraints**

The NGTF held meetings for two hours every other week. Once during the process, the NGTF met for a full day retreat at a site external to the Hospitals. One participant felt that the scheduling of meetings every other week hindered the process. They felt that more was accomplished at a full day retreat than at the biweekly, two hour meetings.

> I think one of the things that may have hindered us was that we had fairly short meetings regularly, once every two weeks. I saw that we got the majority of the work done when we had a full day retreat. People could get in and focus; do some brainstorming, and come out at the end with something. Whereas when you have meetings for two hours every two weeks, you sometimes just get started and have to stop because time is up. The timing of our meetings may have stood in the way of our progress. It also extended the length of the process. (Lambda)

Another participant felt that too much time was spent revising the Philosophy of the Nursing Division, when the Task Force only had a mandate to recommend a revision of the philosophy and not the authority to change it. Input was sought from all staff within the nursing division. The facilitator also sought input from other members of the executive team who were not within the Nursing Division. The revisions of the Philosophy were presented to Nursing Council who then made the final decision. That participant felt that the input from the people external to the Nursing Division was included and input from the nursing staff was largely ignored, as evidenced by the following statement:

> ...we spent a long time on the philosophy. I felt that we got bogged down with numerous drafts coming back and forth. Some people didn't like the wording and we didn't have the authority to come up with our own wording

> for our philosophy. Other faculties or other parts of the Hospitals didn't seem to agree with it. We had the mandate to change the philosophy, but our control was fairly limited. We ended up changing a lot of things that we felt would be good parts to the philosophy (Eta).

One participant felt that the time allotted for the task (to develop a model of nursing governance) was too limiting.

> I would have liked to have seen it done a little more slowly, over a longer period of time, with more education for the people that were on the committee, etc. before we started. (Kappa)

**The Role of the Facilitator**

One participant felt that having the Vice-President of Nursing as the facilitator hindered the process as the VPN was not totally objective and directed much of the action.

> It might have made us more honest if we had had somebody who was totally objective, who would ask the questions and who would have gotten us on track and made us look at things when we were avoiding actually dealing with things. The facilitator has the power, the money, the resources and the ability to make this thing come to fruition. Perhaps what we needed was a really skillful chair who again would have asked the questions because they would have known what questions to ask, but they would have felt some equality from the power point of view. And I don't think that was there (Delta).

Two of the participants felt that there were no hindering factors to the process.

> There have been subsequently, after implementation, some factors that have hindered. But as far as the development of the process goes, I thought that it was one of the most exciting, progressive and fast moving processes that I have ever been involved in. (Beta)

> There were some tough decisions, and tough obstacles to overcome, but that is inevitable with that kind of process that we were undertaking. I don't think there were any particular hindrances. (Epsilon)

## Overall Perceptions

All ten participants felt that the process was unique and valuable. The following comments from all ten participants reflect the broad range of positive perceptions of the process.

> My overall perception of the process was a positive one. I thought it was one of the most exciting and progressive and fast moving processes that I have ever been involved in. It was interesting to me that the group determined that before they could develop this specific model, that they needed to revisit the philosophy on which the model would be based. So, the initial work really did focus on the redevelopment of the nursing philosophy and subsequent review of that throughout all levels of the organization. That, in my mind, made the need for a philosophical base for something like this really important. I found it really neat to see how every member of the group came to that conclusion at about the same time. It wasn't just an exercise for the sake of doing it; it was a very meaningful exercise for all those involved. (Beta)

> I thought the process was very open-ended, very open as far as membership went. We put out the call for membership, and it was open to everyone. We initially had more applications that all the people that we could use. We tried to accommodate them all and then the numbers began to dwindle as people realized that they couldn't make a time commitment to the committee. But we had started out including almost everyone who applied. In one way or another, either as a member or as a resource, we used everybody that applied. We did a lot of advertising of decisions and what was going to come up at meetings; we did that through a newsletter and the Tandem (computer) System. We tried to ask for input at various stages. We did this for the documents that were developed as a result of the work that the committee was doing such as the philosophy, the mission, the vision

statement for the Nursing Division. Those documents were circulated widely. We tried to circulate them to every staff member and get their input. And we got quite a lot and we incorporated what we got into the documents. So I really felt that the process included as many people as wanted to be included. Afterwards, I remember hearing comments along the line or similar to "We weren't asked for our input on this or that". And I remember thinking "We have; we have; a zillion times, we've asked you to give us your input on that. Come to a meeting. Tell us how you feel about this sort of thing". I really feel that the committee did work very hard to get the input of anybody who wanted to give some. I would very mush describe this as a positive experience. I enjoyed working with the members of the group. I enjoyed the process. I think that I learned quite a bit about how involved some things can be. When the committee was first formed, I don't think anybody had any idea of how really wide-ranging it would be or what we would end up with. I know that I didn't. I found it very educational. (Gamma)

I think the process was good. I think there was a willing willingness of people to get involved. I think it was a worthwhile process, and I think what we got out of it a model of shared governance was worthwhile. I'm sure that by the time ten years has gone by, we will have a viable model where there will be representation at every level,but I think there will be quite a lot of changes along the way before we get to that point. (Delta)

I think the process was extremely successful. I think the entire process was extremely valuable and the end result was a very positive and successful model. The potential for a successful model was built out of the process. I think the group worked well together. I think there was a commitment by all parties to build on it and make something that was going to be workable in our place of work. (Epsilon)

I was excited throughout the whole process. I though it was a great thing. I really felt that it was the first time that administrators, nurse managers and staff nurses could actually sit around a table and work through a process towards a goal of nursing governance. I felt that we really had a good working group going. The group dynamics were very good. The process

worked quite well. We definitely had out ups and downs, but overall, from anything that I had ever experiences, it was a good experience. It was a very positive one. I though the process went quite smoothly overall. (Eta)

I really enjoyed it. I though we did a very, very, very good job. I have never been in a group that was more supportive for making decisions and committed to coming up with a model that would empower the staff, and to making it work, as that group was. It was a pleasure to be a member of that group. (Theta)

The process was good. But I want to get a better word than good. I think we all learned from it; it was educational; it was timely; I didn't feel that it wasted a lot of time; it was interesting, and it was fun, for the most part. (Iota)

It was very much an interesting and learning process for me. (Zeta)

The process was such a new concept to me. I would do it again, but I would do it differently. I have found the last four years at this hospital more rewarding in my nursing career than I have ever found before. It is because of the educational opportunities that are offered. This was something new. We made some mistakes, but we tried it. I've never been involved in anything like this before. all it did was make me hungry for more. Yes, I felt frustrated at time and at time totally ignorant, but this process opened my eyes. I was able to take a lot of this back to my unit. It was a learning process. (Kappa)

It was a valuable process. It certainly showed that everybody can learn from somebody else. That was one of the keys in having people from various departments and levels involved. I think the process could be used for as number of different things; it doesn't have to be used just for nursing governance. I think the use of the different tools and techniques involved, is probably something that nurses on this committee have used since, both in there work lives and their personal lives. I think probably the people on that committee gained a new respect for each other, for what they did and what they could offer. I think there was a real sense of team effort. It

> wasn't perfect, but you build from that. I was beginning to see changes in people on that committee in a variety of situations. It was really great to so people much more involved in making decisions. I think it was unique. I think it should be written up and published. One of the keys to the success of the Task Force was that they did not take anything that already existed and mold it to their situation. They started from. By reading about shared governance and taking certain aspects, they made something that would work for this institution. It kept people's motivation up and it gave them a great deal of pride in the work that they were doing. This is because this was their model and not someone else's. They could see the pitfalls and tried to compensate for those ahead of time. They could use that and decide as to whether they would accept a particular aspect or not. I think it was a lot of fun. I'm glad it happened. (Lambda)

In addition to having positive perceptions regarding the process, six participants also expressed negative perceptions. The following comments reflex the broad range of negative perceptions of the process.

> I guess if there is one factor that I would identify as causing problems, after the fact, in some situations not all members were in attendance at all meetings. In reflection, and understanding some of the problems that we're encountering now, I have the feeling that some of them are related to the fact that certain members weren't in attendance when particular decisions were made. That in retrospect is becoming a big problem. (Beta)

> My main consideration would be the weighting of the committee, the change that was going on in the institution at that time and whether you got a "realistic model". I think people didn't really understand the Resource Council. I think there was a real misconception out there as to what exactly the decision-making power of the Resource Council was going to be. It was much easier looking at the other councils. I think these ones flew really well. There was a good deal of misunderstanding as to what powers that council would have, and I think that was the main thing. One thing I would like to see, if it was done again, was a broader representation. There were

many groups of nurses in the Hospitals who were not represented, like Clinical Co-ordinators, and Nurse Educators. Although we had someone from the School of Nursing, I think that the educator role at that point was under represented. There were a lot or resources in the institution that I don't think were tapped enough. I think they could have been. I think a broader base of people was needed. But, then I'm not sure that you would get the "buy in" of the staff nurses. You'd have to fine some way of making sure that there was an inclusion of all groups. And I'm not sure how you do that. I think the weighting would have to be different. I would also have the committee chaired by someone who was not immediately involved in the process and didn't have anything to gain or lose by it. I would have an objective chair of the committee. It could be internal to the institution, but it has to be somebody who doesn't have anything tied up in the result. The chair was very supportive of this process and wanted a model. I think that may have been something in itself that made a difference to the model that we got. It might have made us more honest if we had had somebody who was totally objective, somebody who would ask the questions, somebody who would have gotten us on track or somebody who would have made us look at things when we were avoiding dealing with things. The chair, I mean the facilitator, not the chair, directed much of the action. The facilitator also had the power, the facilitator has the money, the resources, and the ability to make things come to fruition. Perhaps what we really needed was a really skillful chair who, again would have asked the questions because they would have to know what questions to ask, but also they would have felt some equality from the power point of view. I don't think that was there. The other thing that we had happening, was that the staff nurse component of the committee was changing quite a lot in the first stage. We would have people there for two meetings, and then not there. Then we would have new people coming on. It seem to me that it was pretty inconsistent for quite a few months. I think that the kind of skills and the consistency wasn't there at the staff nurse level and I think that was a problem. If you had an objective and skillful chair plus consistency with the staff nurse members, it would have helped the process. (Delta)

I think, in retrospect, that the Union should have come out with a bit more stronger position statement on their role in the task force, particularly in

regards to the structure. For mush of the time the Union was a resource but didn't provide enough position in direction on some issues. (Epsilon)

Towards the end, when crucial decisions were being made, I feel there wasn't enough support from the Vice-President Nursing towards those decisions in order to make it go. Perhaps we needed to take a little bit of time at the end to forecast the upcoming financial climate and how it would affect the model. We could then have troubleshooted in case there were ever problems. (Theta)

The product that came out, I could buy into, but the timing in the institution was just not right for it. People in nursing are educated people and they have the right to use that education. We have been taught to deal with crises and interventions in our schools, in our backgrounds. We haven't had the ability to use it without checking with somebody else. I think the fact that people's educations are changing and they do not want to be held down. Their standards of practice are being limited. I think at the right time within the institution, the nursing governance model would have flown. I think there are pockets of it being lived in the Hospitals, but not on as great a scale as the potential of it was. I think perhaps there should have been a bit more of a learning experience an orientation prior to it, putting everyone on the same basic level. Myself I would have been more comfortable. I'm sure there were others who felt that way. There were days that I would walk out of a meeting and say to myself "I'm not sure why I was there or why I should have been there". But I would do it again. (Zeta)

I felt ownership of the model to a certain extent. But I felt that I was lead by the facilitator. This was really her model. Lead sometimes, facilitated sometimes. It was very strong, but it was friendly leadership. We were coached along the way to the way she wanted it. She did not object but really came at it from a different angle. She lead us to a certain extent. (Kappa)

## Summary

This chapter has presented the critical findings of the study. All comments recorded in the interviews were deemed to be important to both the participants and the researcher and were reported in this chapter. Having some prior knowledge regarding change and the change process was beneficial to the process. This process involved a massive "second-order change" which involved a total restructuring of the Nursing Division which included a redefinition of the philosophy, goals, mission, vision, structure and roles as well addressing the decentralized decision-making process. The broad depth of motivation to join and to remain on the NGTF was identified. The representation from personnel within the Nursing Division were nurses. The members of the Canadian Health Care Guild (CHCG), who are also employees within the Nursing Division, were not represented on this Task Force. The Local President of the CHCG was an ex-officio member of the Task Force who's role was to ensure that the collective agreement was upheld. A clear definition of the decision-making process, consensus, is vital to the process. All members of the group must be functioning under the same assumptions regarding who has the power and authority to make decisions within the organization. Positive attitudes of the members facilitated the process and negative attitudes of some members, the Nurse Manager group within the Nursing Division and some staff hindered the process. The availability of resources, both human and fiscal facilitated the process. Fluctuating membership and inconsistent attendance at meeting had negative effects and hindered the process. The scheduling of meetings and the release of staff to attend meetings was important for consistent attendance by members. Having the availability of the Job Enhancement Funds was essential to allow some of the members, particularly the staff nurses, to attend the meetings. Without those funds, some staff nurses could not be freed from their units to participate in this process. Having a skilled facilitator who was internal to the organization, who was the VPN, who had appointed the members to the NGTF, who had a vested

interest in the process, who had the ultimate decision-making power and authority by virtue of position, was perceived as being both positive and negative.

# CHAPTER SIX: DISCUSSION, CONCLUSIONS AND IMPLICATIONS

This chapter will provide a brief summary of the study. A discussion of the critical findings, personal reflections, and conclusions of the study will be discussed in light of the literature. A set of recommendations which outlines a process to develop a model of shared governance is included. Implications for nursing practice and further research will be identified and described.

## Summary

Little research has been conducted about the process used to develop a model of nursing governance. Much of the literature addresses the application of Porter-O'Grady's model of shared governance within large , non-unionized hospitals in the United States. A search of the literature revealed that, although models of nursing governance exist, the process used to develop the models had not been described in the literature.

This study was designed to describe the perceptions of the University of Alberta Hospitals' Nursing Governance Task Force (UAH NGTF) regarding the process used to develop the C.A.R.E. (Co-operation; Accountability; Respect; Empowerment) Model of Nursing Governance. The study sought to describe the demographics of the NGTF, the motivation to both join the NGTF and to remain on the Task Force, the decision-making process on the NGTF, and the perceptions of factors that facilitated and hindered the process. The perceptions of staff nurses, management and unions were identified and discussed.

## Discussion

The following section discusses the findings of this study. The discussion of the findings is grouped into five major categories derived from the topic areas that were discussed in the interviews. The categories are: characteristics of the participants, motivation, decision-making within the process, facilitating factors and hindering factors. Subcategories emerged from the major categories. A discussion comparing and contrasting

the perceptions of management , staff nurses, and the unions is also included in this chapter. All comments, both positive and negative will be discussed.

**Characteristics of the Participants**

The members of the NGTF who had graduate education in addition to many years of experience in nursing appeared to be more comfortable with the process of developing the model of nursing governance than the members of the NGTF who did not have graduate education. In their graduate school and work experiences they would have been exposed to change theories. These members tended to be the administrative/management representation on the Task Force. In addition to further degree education, they had had a variety of administrative experiences. The staff nurses who had baccalaureate or post-basic education were employed in the role of the staff nurse and had had limited administrative experiences. Not only were management group able to identify resistance to change and the benefits of change, they were able to facilitate the planning and implementation. They recognized that feelings of fear of the unknown, confusion, frustration and loss were the resistors to change that Schermerhorn Jr. et al (1992) had identified. As a result they were able to guide or facilitate the process for the staff nurses. Some of the staff nurses felt that they had been manipulated or had had a model imposed on them, when in the opinion of the researcher they had been guided through a planned change process by a skilled facilitator. The products of the process, a model of nursing governance and a revised Vision Statement, Mission Statement, and Philosophy for the Nursing Division, were developed by the Task Force, but were guided through the process by the facilitator and the administrative representatives.

The members of the NGTF who held management positions within the Hospitals had received initial orientation to the UAH QI (University of Alberta Hospitals' Quality Improvement) Programs. Many had proceeded through the initial phases and had completed or were completing the final level. They were also acting as facilitators to other groups that were proceeding through the ACHIEVE programs. The researcher believes

that this influenced their role within the NGTF. They had been exposed to and had developed some expertise with the group process. They were entering the process at a very different starting point than the other members of the NGTF.

The members of the NGTF that had baccalaureate or graduate school education were certainly familiar with the process of developing literature searches, summarizing articles, and making presentations to the general hospital population. Because of their past experience they brought an ability to look at the *whole picture in a broader perspective*.

**Motivation**

Members joined the NGTF for one of three following reasons: 1) volunteering to meet personal goals, 2) volunteering as a representative of a particular stakeholder group and 3) representation by virtue of their position. The three staff nurses that joined the Task Force to meet their own personal goals. The remaining seven members that were on the Task Force were representatives of a stakeholder group, either management or union.

Overall the participants felt that the process was very educational and contributed to both their personal and professional growth. They found the experience personally rewarding. Even though change can be threatening and cause confusion, fear, and contrasting interpretations (Schermerhorn Jr. et al, 1992), members did make the commitment to be on the Task Force

Throughout the process they gained a new respect for others and became aware of others' roles and responsibilities. Initially the staff nurses did not realize the scope of managements roles, nor did management realize the scope of the staff nurse role. The NGTF came to the conclusion that the role of the Nurse Manager would require redefining. The Nurse Manager group had been identified as a key element in this change process. The NGTF identified that an extensive orientation to the new roles that would be expected for the Nurse Managers would be necessary. This would include an orientation to the group process, the consensus decision-making process and to the role of a facilitator. It was felt that the expectations for change within this group were the highest of all the within the

Nursing Division, and yet the least amount of attention was given to provide them with an orientation to the change process and the operationalization of the governance model. An extensive orientation to the new role that would be expected of the Nurse Managers was going to be required.

Even though the participants admitted there was a tremendous amount of work that was required, they would do it all again. In observing the members talking about the Task Force and the C.A.R.E. Model, it was evident to the researcher that they were keen and enthusiastic about it. Not only for what they had personally gained from the process, but what shared governance could do for nursing within the institution. They expressed a tremendous amount of pride and ownership in both the process and the model, as well as regret that the implementation of the model had been halted.

### Decision-Making Within the Process

Three reasons for difficulties with the decision-making process used by the Task Force emerged from the data that were collected. They were: 1) lack of total understanding by the group of the process of consensus-building, 2) the non-commitment to the consensus process by some members of the group and 3) membership of the Task Force having union officials having an equal voice with management.

A clear, concise explanation and commitment to consensus, as the form of decision-making, was not determined at the start of the process. Throughout the process it remained unclear if all participants understood what consensus meant within the context of the Task Force. The process of consensus building was labored; all participants agreed that it took time and trust to develop that process.

The participants felt that decision-making was done by consensus, but they never defined consensus within the group nor did they discuss how consensus decision-making was to be used for decisions that arose. There were times when some members of the group did not adhere to any form of decision-making method. One participant expressed the opinion that one member of the committee, who was in a management position and had

a strong, opinionated personality, was not speaking their opinion and was inconsistent in supporting the decisions that NGTF made. This member would remain quiet during the decision-making process at a meeting and then become vocal outside the meeting. This was an attempt to get their views across to others within the Hospitals, but not the Task Force members. The question is raised by the researcher if this was *a subversive attempt to manipulate non--management members to change their point of view to the managements perspective?*

Another member was concerned that the Union, Staff Nurses Association of Alberta (SNAA), was representing only Union views and not necessarily those of nursing. The staff nurses, Clinical Supervisors and the Nurse Educator (the researcher) were all union members. These members were expressing nursing concerns from a nursing context as well as a union context. The Union was participating as an equal member in this process. The major concern of the Union appeared to be: *could this model be compatible with the current contracts?* The Union did not appear to have difficulty with the model, and offered their support of the process of decentralized decision- making. One member of the Task Force , who was in a management position and who was not a member of the Union, was having a difficult time letting go of the control that they currently held. Under the new structure, control for decision-making was moving from the management to the staff nurses, and the roles of management would change dramatically.

These concerns been could have been resolved by establishing a clear definition and an understanding of consensus at the beginning of the process, thus eliminating some of the difficulties.

### Factors that Facilitated the Process

Facilitating factors were both internal and external to the group All the factors that the participants identified have been included in these findings. These facilitating factors were grouped into three broad categories. The factors have been identified as: 1) the positive attitudes of Task Force members which includes the composition of the Task Force

and the environment within the Task Force; 2) resources which includes availability of funds, the use of resource people, participation in the UAH QI Programs, and the use of the QI "Tools and Techniques"; 3) time elements which include staff scheduling and peer support, and the flexibility to negotiate alteration in the "critical path". No one of these factors was noted to be of more importance than the other two. All three factors were critical to facilitate the process.

**Positive Attitudes and Environment**

The positive attitude that existed within the Task Force was one of the greatest facilitating factors. This positive attitude was described and expressed through comments on motivation, enthusiasm, commitment, openness, honesty, friendliness, and equality. Friendships and new collegial relationships developed between members of the committee. Management, union and staff nurses treated other committee members as colleagues and peers early in the process. Much of this collegiality was lost when further layoffs occurred in July 1992. This was a corporate decision and there was little, if any, involvement from the council level. This lead to strained relationships between the Union and management. At that point, the Union felt that management had betrayed the staff and withdrew their support from the nursing governance model. On a more personal basis, the relationships between the NGTF members has not changed. As a result of the process that the group worked through, they established firm collegial relationships that continue to thrive. This resulted from the professional growth that comes from a sense of mastery or accomplishment which is a subjective result of change (Fullen, 1991, p.32).

The composition of the group itself was considered to be another facilitating factor which affected the attitudes of the Task Force. The Task Force was made up of members who represented a cross section of the Nursing Division from management to staff nurses to union officials. This broad representation allowed for all areas of the Nursing Division to be able to express opinion as to the effect that this change would have on their areas. The NGTF did not have a closed membership for staff nurses. There was also a deliberate

attempt to have the majority of members representing non-management staff and therefore the numbers of Task Force members who represented management were limited to three. There was no intent to limit the number of staff nurses on the Task Force. The NGTF selected staff nurses as the Chair and Co-chair. Any staff nurse who wished to join was encouraged to do so. Many members of the NGTF were not part of the core group who developed the model, but were used as resources, for example: 1) during the revision of the Philosophy, a member of the Nursing Division who was doctorally prepared and who had a great deal of experience in nursing service and education, was used to consolidate the opinions of the general staff as well as the Task Force into the final format for presentation to the Nursing Council; 2) the model was named by a staff nurse whose entry in the "Name the Governance Model" was selected by the Task Forces as being the most suitable; and 3) the publishing of the weekly newsletter by members of the Task Force who were not part of the core group but were assisted by core group members.

The general environment that existed within the NGTF was described as open, free, friendly and non-threatening and was felt to have developed from the positive attitudes of the group members. There was a mixed range of opinions which varied from members feeling that they could voice their opinions and those opinions were valued to others who were feeling that they were "guided" , and even "manipulated", by the facilitator in a predetermined direction. This generally positive environment was established by a skilled and experienced facilitator who was committed, resilient, flexible, open and creative and who was able to guide the process of transformation to shared governance (Kruger, 1989). Some members who felt that the Task Force was manipulated by the facilitator who not only had a predetermined vision of what shared governance should be, but who had a vested interest in the process and end-result by virtue of the position that they held, the Vice-President Nursing. The facilitator had the power and the resources (money) to control the development of the governance model.

**Resources**

The availability of Job Enhancement Funds definitely facilitated the process, as they allowed for relief dollars to allow members of the NGTF to attend meetings. These funds were applied for by the VPN and were not available to the Task Force for several months into the task. These funds remained available for the duration of the development process and the surplus had been identified for use during the development process as a source of educational and orientation funds. They were not available for staff nurses to use for relief once the Model was operational as it was an expectation that the Decentralized Councils would arrange schedules to allow their members to attend meetings. The researcher agrees that when these funds became available to provide for relief for members to attend meetings, Task Force members were able to get involved and remain committed to the project. In addition, the resentment by remaining staff decreased because they were not continually being asked to pick up the workload to free a staff member to attend meetings. These funds were limited and would no longer be available once the model was operational. A concern arose as to how to allow people the time to function on the committees. This was a particular concern for the staff nurses, as their primary function was patient care.

In the restructuring of the Nursing Division with this model, the Nurse Managers would act as facilitators to the Decentralized Councils; the Directors of Nursing (DONs) would act as facilitators to the Divisional Councils, and the Vice-President Nursing would act as a facilitator and an advisor to the Co-ordinating Council. The Nurse Managers, Directors of Nursing and the Vice-President Nursing would all have revised job descriptions which would reflect their new roles and responsibilities, but the staff nurses would continue to be the frontline workers who provided patient care. In the restructuring and redefining of the Nurse Managers' roles, they would be required to relinquish the power and control that they traditionally had and would be required to become skilled facilitators of the decentralized councils. The Directors of Nursing would also have

alterations and restructuring of their roles and functions but to a lesser degree than the Nurse Managers.

Resource persons were an effective facilitator to the entire process. The availability of resource people from the UAH QI Program facilitated and assisted the NGTF through several tasks throughout the process. Other resource persons provided background information on models of nursing governance in place in the United States. The researcher had shared the literature review with the members of the UAH School of Nursing's Committee on Committees (2C), which was also in the process of developing a shared governance model. That group in turn shared their resources.

Members were divided in their opinions as to the value of all members having participated in the Hospitals' QI Programs. Some felt that it was beneficial to have participated in the programs and all the members of the NGTF should have experienced the basic ACHIEVE level. Others felt that it was more beneficial to the process to be at different levels. All felt that the UAH QI Program would be compatible with and benefit both the development and the implementation processes of a model of nursing governance.

The development process was definitely enhanced by having a facilitator who had not only proceeded through all of the ACHIEVE programs, but was a skilled facilitator at group process. The facilitator to this process, the VPN, had functioned in other positions as a facilitator to change processes. Having support for the facilitator in the form of other members of the management teams who had also had similar experiences with the ACHIEVE Programs enhanced the whole process. The staff nurses had not all begun to proceed through the programs. This proved to be a liability to the process as much time was spent on the development of a cohesive, functioning group. Perhaps if all members of the Task Force had had the introductory programs, Group Action and Problem Solving, much of the dissention regarding decision-making and the definition of consensus would have been avoided. Also the concerns of the facilitator was guiding the group to a preselected ending, or the feelings of being manipulated, would have been reduced if not

eliminated. These issues were never addressed by the group nor was the issue of whether the facilitator should have a vested interest in the outcome of the group or whether the facilitator should be external to the group or organization and have not control or resources to influence the outcome.

As part of the development and implementation process, the NGTF members that had not taken the introductory Group Action Program arranged to attend special sessions. Once they had assimilated the process, they would,become the facilitators who would assist the staff nurses with the transformation.

Only three participants felt that use of the "Tools and Techniques" of the UAH QI Program was a facilitating factor. The general perception of the NGTF was that participation in the UAH QI Programs and the use of a skilled facilitator in group process was more important than the actual tools or techniques that were used.

**Timing**

The participants identified that having funds available for relief was only one part of the complex puzzle which allowed members to attend meetings on a regular basis. Staff scheduling and peer support on the units for the representative was important. It either facilitated or hindered the process and attendance at meetings, depending on the units and their individual situations. If the staff on the Nursing Units saw this restructuring and development of a model of nursing governance as important, then those same staff members supported the NGTF members who worked on the units in a variety of ways. The staff who were committed would cover the unit or would change rotations to allow the member to attend meetings. If the staff did not support the member or "buy into" the concept of shared governance, then that same staff made it very difficult for the member to attend meetings on a regular basis. This was the only reason voiced for poor attendance, as many of the staff nurses on the Task Force came in to meetings when they were on days off, evenings or nights.

The flexibility to negotiate alterations in the "critical path" was identified by one participant as a facilitator to the process. However, the ability to alter the timeline was not a major issue within the process. With minor alterations in the timeline, the NGTF completed the mandate handed to them by the Nursing Council, which was to present a model of nursing governance in early October, 1991 (which NGTF did).

## Hindering Factors

Factors that hindered the process were both internal and external to the group. They have been identified as: 1) negative attitudes of some members of the NGTF, the nurse manager group and nursing staff; 2) fluctuating membership which included the inconsistent attendance at meetings; 3) time constraints which included the scheduling of meetings, the time spent revising the philosophy and time allotted to the NGTF to complete the task, and 4) the role of the facilitator who was the Vice-President Nursing and had a vested interest in the process. No one of these factors was deemed to be of more importance than the other three. The presence of any one of the hindering factors could pose difficulty with the process.

### Attitudes

The negative attitudes of some members of NGTF hindered the process. Some members identified these as 1) an unwillingness by some members to admit that there were difficulties with the process, 2) a reluctance to change, 3) mistrust of management by some of the members and the unions, and 4) pre-expectations particularly regarding the types of decisions that staff nurses would be making. The reluctance to change, and the mistrust of management, accompanied by feelings of loss, confusion and discomfort, have been identified by Schermerhorn Jr. et al (1992) as being reasons for resisting change.

One member felt very strongly that the Task Force was reluctant to admit within the group that there were difficulties with the process. Other members acknowledged that there were difficulties within the group and with the process. One of the these difficulties arose with the development of a Nursing Division Vision, Mission Statement and Philosophy of

Nursing which reflected the concepts of shared governance. Some members of the Task Force resented the time spent on revising the Philosophy, especially when input from non-nursing members (doctors, administrators) was incorporated into the statements. They felt the time would have been better spent on planning the implementation of the model. The need to address the process of decision-making within the model was an area that members identified a reluctance to address. The Task Force never did address the issue of consensus as a form of decision-making. Neither was there a discussion for the need for a source of funding to provide relief in order that members could attend meetings of the Task Force. It was expected that Nursing Units would attempt to provide internal relief or alter schedules to allow NGTF members to attend meetings. Only when this was not possible was the Nursing Unit to rely on funds for relief for Task Force members.

Some members were reluctant to change from the existing style of governance to a shared governance style. They were willing to maintain the "status quo", rather than shifting their paradigm to a new form of governance which gave nurses within the Nursing Division the responsibility and authority to make decisions that affected their working environment. The management members around the table were committed to a new form of governance, as were the staff nurses. The middle management group, the Nurse Managers, and the union representatives were somewhat reluctant to trust that management was going to hand over the power for decision-making and governance to the staff nurses. Neither group trusted that management would allow nurses to make all the decisions that they had stated that nurses could have control over. They didn't believe that management was going to change from a directing and controlling role to a role of facilitating the decision making process. The Nurse Managers felt that they were going to lose the power and control over decisions that they had traditionally made. They expressed concerns that they would be held accountable for those same decisions which they did not make. The unions expressed concerns that some decisions that would be made would conflict with the terms of the Collective Agreements that were in place.

One member felt very strongly that the Task Force was reluctant to admit within the group that there were difficulties with the process. Other members acknowledged that there were difficulties within the group and with the process. These difficulties included the need to develop a Nursing Division Philosophy of Nursing which reflected the concepts of shared governance; the need to address the process of decision making within the model; and,the need for a source of funding to provide relief in order that members could attend meetings of the Task Force.

Two participants felt that the attitudes of the nurse managers hindered the process. Once the model had been developed, the nurse managers had been identified as a crucial part of the model as they had been designated as the facilitators of the decentralized councils. Two participants felt that this group of employees were caught in the middle between management and the unions and as a result were both the most non-supportive group to the process and the most non-supported group within the Nursing Division. It was acknowledged by the Task force as a whole, that the group that was going to be affected the most by this change was the Nurse Managers, and as a group they resisted the change the most. This in part was reflected by a Nurse Manager on the NGTF who may not have reflected the views of the total Nurse Manager group. Many of the view were personal. As a result the Nurse Managers were perceived to have the most to lose and the most changing to do, and yet they had the least amount of attention paid to them. There were extensive orientations planned for the staff nurses to help them buy into shared governance, but there was less planning and orientation for the Nurse Managers. In order for this change to successfully be implemented, there needed to be a commitment and a *buy into* shared governance by the Nurse Managers. They had to come to believe that this change was a positive change worth personal investment not only for themselves, but for the staff, the patients, the institution, and the Unions, the SNAA and the CHCG (House, 1974, in Fullen, 1992, p. 34). Once they had incorporated that belief, they would become the facilitators who would assist the staff nurses with the transformation.

The attitudes of staff within the Nursing Division varied. There was resistance to change among the general population. Several years earlier, a form of shared governance had been implemented with limited success and much resistance (Hibberd, Storoz & Andrews, 1992). As a result, the staff were wary and reluctant to buy into anything new. Another participant felt that the NGTF waited too long to communicate with the staff and as a result the staff felt a lack of ownership and this hindered the process. The researcher felt that the governance model was definitely owned by the members of the Task Force, but the general nursing population had not yet bought into the change process.

**Fluctuating Membership**

Five participants felt that the fluctuating membership was a result of noncommitment to the process. No data were collected to support or refute those statements. Those statements were the personal perceptions of members of the NGTF. In retrospect, members ceased to belong to the NGTF when they realized the time commitment involved, when they did not garner the support of their peers to attend the meetings, or when they experienced great difficulties in being released form the units to attend. The changing of membership occurred prior to the Job Enhancement Funds being available for this project.

The inconsistent attendance was due to a variety of reasons related to previous work and professional development commitments, personal commitments and the inability to reschedule shifts or obtain required relief. This resulted in valuable time being spent to "reorient" or "catch up" absent members on the process or decisions that had been made. Once the member had committed to the NGTF, they attempted to arrange and rearrange their schedules and personal lives to accommodate the workings of the Task Force, but this was not always possible. The underlying principal in all of this is *commitment to a process*. The change became meaningful to the members of the NGTF and that was when they made the sincere commitment to participate in the process (Fullen, 1991, p. 37).

The confusion surrounding the Task Force membership issue and weighting on the NGTF revolved around who would be accountable and responsible for the decisions and who would be in authority to make the decisions (ie. decisions which would have direct impact on the contracts that existed between the unions and the Hospitals). A commitment to the process of shared governance, a restructuring of the Nursing Division, and a redefining of the roles of all the players involved in the process would resolve this issue. But only if the players involved truly *bought into* the change. As Marris (1975 in Fullen, 1991, p.31) states "*all* real change involves loss, anxiety and struggle". Personal meaning has been attached to the change by all members of the NGTF and many were displaying anxiety and were struggling over their loss of the former status quo.

**Time Constraints**

Another factor that was perceived to hinder the process was the scheduling of meetings. One member felt that more was accomplished at full day retreats than at the biweekly, two hour meetings. The scheduling of the meetings hindered, as well as lengthened the process.

One member felt that too much time was spent revising the Philosophy of the Nursing Division, when the Task Force only had a mandate to revise the philosophy but not the authority to change it. That member felt that people external to the Nursing Division exerted too much control on what the Philosophy of the Nursing Division should be.

Another participant felt that the time allotted for the task to develop a model of nursing governance was too limited and should have been extended over a longer period of time with more orientation for the Task Force to the process. That member also felt that all members of the NGTF should have experienced at least the ACHIEVE level of the QI Program. They felt that much time was lost orientating members to group process. If all members had had the ACHIEVE Program, then they would have been exposed to the process.

**The Role of the Facilitator to the Process**

One member felt that having the Vice-President of Nursing as the facilitator, was a hindrance. As the facilitator, the VPN had the skills and knowledge, the power, the money, and the resources to assist the NGTF with the development of the model, but by virtue of the position, the VPN was not totally objective and was too directive of the process. It was also felt that the facilitator had a vested interest in the process as well as the outcome of the Task Force. This member felt that the facilitator for a task which involved such a major change, should be external to the division, if not the organization.

The Vice-President Nursing, who was a skilled facilitator, was self-appointed as facilitator to the process. The VPN had the vision as to the direction the process would take. In addition to being the facilitator to the process, the VPN requested interested staff nurses within the Nursing Division willing to be on the Task Force. The VPN then selected the members who would be on the Task Force. The Nurse Managers group requested that the VPN include a representative from their group be included in the membership. The Nurse Managers selected their representative. The VPN also controlled the funds of the Nursing Division. As a result the VPN was perceived to be an extremely powerful member of the Task Force. Initially, the Task Force was limited to three members of management, including the VPN, four staff nurses and two union officials. As work proceeded a Clinical Supervisor and additional staff nurses joined the Task Force.

**Management Versus Unions Versus Staff Nurses Perceptions**

The direct comments from management, the unions and staff nurses did not reflect any major differences in their perceptions of the process. Upon analysis of the comments the following emerged. Senior management's role was to facilitate the transition from a current organizational structure to the new structure. During the process they provided a broad perspective.

Middle management, the Nurse Managers, were the most obstructive to the process. They were the group most affected with this change in terms of changing their roles, relinquishing of their authority and control to make decisions, and being expected to assume the role of facilitator to the Decentralized Councils. In all of the planning for the restructuring of the organization, they were the group that received the least amount of support form the current management and the Task Force.

The unions' roles in the process of developing a model of shared governance, were to act as "watch-dogs" to ensure that the existing contracts were not contravened. The SNAA, which represented the staff nurses, was a powerful force on the Task Force as they not only had a union official, the Local I President, on the Task Force, but the staff nurses all brought a union perspective to the table.

The staff nurses' role was to work with both management and the unions to develop a model of nursing governance which would increase their autonomy, accountability and responsibility for decision-making, and which would assist them to define, articulate and evaluate their practice. The staff nurses were the group that would be making the decisions that affected their practice and worklife.

All groups were committed to the task of developing a new model of governance and were actively involved throughout the process. All groups addressed issues that arose and worked collaboratively to resolve the issues within the context of the model. The issue that appeared to cause the greatest amount of discussion, was an issue of power and control. *Who really held the power and how was the power utilized?* Staff nurses, and in particular the Unions, were concerned who would have the authority to make decisions regarding layoffs and bed closures that would ensue from further government cutbacks in hospital funding. This issue appeared to fall under the realm of the Resource Management Council. The Unions supported the power and authority coming under the Resource Management Council. The unions were trying to ensure that they would have a say in those decisions made at the councilar level and they felt strongly that those decisions should

rest with the Resource Management Council. The unions were also monitoring decisions to ensure that they did not contravene the existing contracts. The staff nurses wanted to have control of those decisions, as the decisions directly affected them and their ability to give patient care. But management still considered some decisions as "Corporate Decisions" and were unwilling to have staff nurses make those decisions because those decisions had a much broader reaching effect than just the Nursing Division. "Corporate Decisions "were considered to be decisions that affected more than one division within the Hospitals. They were primarily of a budgetary nature. There was little if any controversy surrounding the roles and functions of the Professional Council, the Practice Council and the Communication and Informatics Council.

Eventually the issue of power and control regarding the decision for further cutbacks and resulting layoffs rested with management. In the Fall of 1992, the unions' executives withdrew their support of the shared governance model abruptly and strongly urged their member to withdraw from it as well. It was not known what information went back to the unions' executives regarding the announcement that there would be further budget cutbacks and layoffs within the Nursing Division. In response to this "Corporate Decision", the unions felt that they had no input into the decision nor authority over the decision. This withdrawal of support appeared to be in relation to the organizational restructuring that was occurring as a result of the implementation of the model and was not as a result of the process that was used to develop the model.

All three groups, management, the union representatives and the staff nurses, stated that the process used to develop the model was very educational and that it contributed to both their personal and professional growth. A real sense of team effort developed and the members felt true ownership for the model they developed. Throughout the process they gained a new respect for others and became aware of others' responsibilities. Many stated they had had "fun" and the majority stated that they would do it again, with the same representation.

## Recommendations Arising from the Discussion

The following recommendations are generic and were complied based on the discussions of the findings of this study. These recommendations could be applied to other tasks or organizations. Factors that facilitated this process are taken into consideration. Hindrances to this process were identified and frequently accompanied by suggestions to avert or eliminate the hindering element. These suggestions have been taken into consideration when developing these recommendations. These recommendations may be considered when undertaking a radical change , such as the change undertaken by the NGTF.

1. Time is required by a group to develop relationships, especially trust, in order to function effectively as a group. Trust must be developed between management, the unions and the workers. Allow time for positive attitudes and collegial relationships to develop. The enthusiasm and commitment that members will display, will contribute to an open,honest, and friendly group. Members may work together to reach a mutual goal or they may work to block the task of the group.
2. Have representation from a cross-section of the stakeholders involved in the change. Include all levels of management, unions and employees within the division. Members can join by volunteering, by election, by selection (as a member of a stakeholder group or their position within the organization) or by coercion.
3. Membership, on a group such as this, must be consistent. A commitment from all members was seen as being important to the functioning of the group. A fluctuating membership will hinder the process. Attendance at the meetings must also be consistent.
4. Members must be willing to drop negative attitudes and a shift paradigms in order to facilitate the process.
5. The facilitator of the process should be skilled and knowledgeable in group process. If the facilitator is a leader within the organization and has the power to

make things happen, then it is recommended that that leader become the facilitator to the group. If that facilitator does not have the power then it is recommended that the facilitator be external to the organization. The facilitator should be chosen for the intent of the role and the power that accompanies the role.

6. It is beneficial to have the group members develop some group process skills prior to commencing the task. They do not need to all be at the same level, as this process is a learning process as well.
7. Encourage a positive attitude and environment within the Task Force by encouraging enthusiasm, commitment, openness, honesty, friendliness, and equality. All members of the group are equal and they have an opinion which is to be valued.
8. Seek alternate sources of funding to allow for relief for members to participate in the task.
9. Resource people can facilitate the process through the use of tools and techniques of group process. Resource people who have had experience with the task either at the same organization or at another organization are valuable to the process.
10. Peer support must be encouraged and there must be a willingness to support the members in their tasks. Reluctance to alter schedules and lack of peer support hinders the process.
11. The ability of a group to be flexible and alter its "critical path", yet accomplish its mandate within the given timeframe is essential. Group members cannot function effectively when that are continually struggling to meet minor deadlines. Meetings should be held on a regular basis. This allows members the time to be adequately prepared for forthcoming meetings. Meetings should be short and planned. This allows members to obtain relief to attend and does not drag the process out.

12. The group must address the negative attitudes and a reluctance to shift paradigms that exist within an organization. A comprehensive communication process between the group and the organization is seen as a resolution to this difficulty.
13. At the beginning of the task, clearly define the decision-making process that the group will use. Make sure all members of the group understand the process and adhere to the process.
14. Communication between the members of the group and the stakeholders in the change process is essential. This communication must be two-way and must occur continually on a regular basis.

## Implications

The data provided in this study provides valuable insights into a process that was used to develop a model of nursing governance. The suggestions included in this chapter may assist other groups in developing a governance model. The lack of literature, particularly literature pertaining to unionized, Canadian hospitals, which describes an actual process used in developing a model of nursing governance, supports the need for further research in this area.

In this study, the members of the Task Force were able to identify and describe the process that they used to develop the C.A.R.E. Model of Nursing Governance. They were able to describe their feelings towards the process. To develop a model of nursing governance that can work in a nursing context, it is necessary to involve nurses at all levels of practice in the process. Nurses, both at the management and staff nurse level, could benefit from the lead taken by the nurses at the University of Alberta Hospitals Nursing Division. They could apply this process in their institution to develop their own model of nursing governance, a model which would meet their needs and be compatible with the philosophy of their institution. This process is not restricted to the development of a governance model. It could be used to work through any group task or change process.

The key to the successful transformation is through group process. One of the

most critical factors of this process is the availability of a skilled and knowledgeable group process facilitator who does not have a vested interest in the outcome of the change. Another critical element is that working knowledge of change theory is necessary for the group to be successful. If nurses wish to continue to be on the leading edge of the rapidly expanding and ever-changing health care delivery system, they must have education that includes decision-making, critical thinking and change theory. They must understand change and the effects of change..They must understand the group process. They must also come with a common set of expectations of how to function in group. They must understand what is needed to make the group work effectively.

The process could by applied in a non-nursing context. This group of nurses participated in a leading-edge decision-making process and have developed internal coherence and a greater sense of self-recognition. A significant thread throughout these implications is the personal growth and the "pride of ownership" that developed in the participants. They have been role models for women in other occupational groups who work in a "masculine bureaucracy". They have demonstrated that a group of predominantly females in a predominantly female working group can work through a group process within a male-dominated and controlled hierarchy. Non-nursing organizations, particularly those with a large group of women in them, could apply this process to any group decision within their organization. This process would then meet their particular needs, address their issues, and be adapted to their setting.

In order for groups to be successful it is necessary for the members of the group to have some working knowledge of how groups function, of change and how it affects an organization and the people in it, of the parameters of the group (who makes the final decisions? who controls the budget? who holds the real power and how much power are they willing to relinquish?). The choice and selection of a skilled facilitator is also very important. The setting that the group meets in, the frequency that the group meets, the time that the group requires to complete that task all influence the success of the group.

**Implications for Further Research**

Other studies have addressed decision-making processes, motivation, change, but there is little in the literature regarding the use of the process of group decision-making to enact change. Further research is needed to support and further define the application of this process to the transformation of an organization.

Once a group has used the process of group decision-making as an instrument of a change process within an organization, further investigation should follow the implementation of the change. Areas that could be investigated might include decision-making, implementation of organizational transformation, cost effectiveness and ultimate results of the change, the selection of the group and the facilitator, the selection of the members of the group (whether they represent a vertical or horizontal cross-section of people within the organization), and the parameters of the change., and the implications of flattening an organization' structure.

Decision-making can be addressed both inter- and intra-organizational levels. Issues such as how decisions are made, who is involved in the decision-making, who has the control over the decisions, who is accountable for the decisions made, and how is accountability addressed once a decision is made are all ares that require further research.

Once a group has used the group process to develop a plan for change and that change has been implemented, research is necessary to evaluate not only the success or failure of the change, but the effectiveness of planning and the implementation that was put into the change process. The effects of the change need to be addressed also. The process must be evaluated in terms of its value in the constantly changing political and economic environment. Change must be evaluated within the context that it occurs. The implications that result from the restructuring of an organization require addressing in terms of the effect on costs, staff moral, and quality of care (or product).

Further research is required on the cost-effectiveness of a change process. The balance between the cost of allowing staff to develop an organizational transformation

needs to be compared to costs of the implementation and the value of the outcome. Was that change worth the time and effort both in human and economic resources? Was the outcome of the transformation really a better way of structuring an organization or was it a different way? What are the benefits to the people within the organization and the the community at large?

The role of the facilitator is very important to the success of failure of a group and ultimately the implementation of change. A facilitator who has a vested interest in the outcome is both hindrance and a benefit to the group. Having a facilitator or leader who had the power to make things happen can benefit a change process (Napier &Gershenfeld, 1993, p. 225). Prior to the undertaking of this change process, the VPN was perceived by the unions and the staff within the Nursing Division as the "power" that was responsible for the first round of layoffs resulting from budgetary cutbacks. The researcher took the stance in this study that having this same skilled facilitator who had power and a vested interest in the outcome of the process was a hindrance. Further research is necessary to confirm this viewpoint or refute it. Who is best suited to facilitate the development of a change process? Does a facilitator. who selected the group and has a vested interest in the outcome, facilitate or manipulate the group? The whole issue of leadership styles requires further investigation.

This particular study involved participants who were part of a vertical cross-section of a bureaucratic hierarchy. The usual group involved in the process of developing an organizational restructuring is a horizontal cross-section of a bureaucratic hierarchy. Further research is required to compare and contrast organizations which have used one or the other of these groups, or both groups, to effect change. Is one method more effective than the other? Will change be more successful with one or the other? Who make the decision as to which group will be involved in the development of the change process?

The effects of parameters on the change process and on the individuals that are involved in the transformation require additional study. Issues such as amount of prior

knowledge of change theory, experience with change, group process skills, types of experience that benefit involvement in a change process, are parameters that vary with each group involved in developing a change.

All change processes should be reported in terms of the process utilized, participants and their place in the institutional hierarchy, the decision-making used, the role and power of the facilitator, the scope of the change, the planning and implementation of the change, and if possible the success or failure of the change and the rational to support it. Other groups involved in change processes can then utilize and alter their parameters to benefit this situation in order to develop and implement effective change.

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## APPENDIX A

Chronology of Events

| | | |
|---|---|---|
| 1988 | Spring | New VPN arrives to replace retiring VPN. |
| 1989 | Winter | Hospitals administration commits to reorganization of Nursing Division.<br>A shared governance structure is proposed. |
| 1989 | Spring | VPN imposes a shared governance structure upon Nursing Division.<br>A Nursing Council is implemented as part of restructuring. |
| 1990 | Summer | Incumbent VPN completes current contract and a new VPN is appointed internally.<br>Nursing Council continues to function.<br>Government of Alberta announces the health care restructuring initiatives |
| 1990 | Fall | First round of budget cutbacks and layoffs occur within the Nursing Division.<br>Most devastating to the organization. Climate within the Hospitals changes dramatically.<br>Middle management is reduced within the Hospitals. Number of Nurse Managers is reduced by 2/3.<br>Position of Clinical Supervisor is created as in-scope position within the SNAA.<br>First time in history of nursing in Alberta that massive layoffs and bumping has occurred. |
| 1991 | Winter | Nursing Council requests that VPN strike a task force to develop a model of nursing governance for the Nursing Division.<br>VPN seeks staff members to become a part of the task force.<br>A DON,a Nurse Educator, and Administrative support, as well as staff nurse representatives from a broad cross-section of the Hospitals are appointed to the Task Force.<br>Union representatives (the recently elected President of Local 1 SNAA and the Local President of the CHCG) are asked by the VPN to join the Task Force. |

Nurse Managers request to place a representative of their group on the Task Force.

VPN appoints self as facilitator to the NGTF.

1991 Spring — Initial meeting of the Nursing Governance Task Force with The VPN, a DON, a Nurse Manager, a Nurse Educator, a Clinical Supervisor, staff nurses, administrative support. and union representatives in attendance.

Literature review is conducted.

1991 Summer — Data gathering from staff occurs.

Input is consolidated and model/framework is developed.

DON replaces a DON on Task Force.

1991 Fall — NGTF presents the C.A.R.E. Model of Nursing Governance to Nursing Council for approval.

One member resigned from NGTF and was not replaced.

NGTF requests to remain as a group to guide the implementation of the model.

Information and education sessions begin with Hospitals' staff.

1992 Winter — Planning begins for implementation.

Education sessions continue with Hospitals' staff.

Philosophy, Mission and Vision statements for the Nursing Division are reviewed, revised and presented to Nursing Council for approval.

1992 Spring — Provincial election gives Conservatives a majority government whose mandate is to eliminate a deficit budget within three years.

Substantial cuts occur within health care.

Further layoffs within the Nursing Division are identified.

NGTF seeks permission from Nursing Council to become the first operational council, the Professional Council, and guide the implementation of the remaining councils.

Decentralized Councils are formed.

Decision-Making Task Force is struck with a mandate to develop a model of decision-making for the shared governance model.

| | | |
|---|---|---|
| | | A "Decision-Making "Model", a set of guidelines, is developed and presented to NGTF. |
| | | NGTF members enroll in the Hospitals' Quality Improvement Program's *Group Action* . |
| | | Directors of Nursing are assigned to act as facilitators for the four divisional councils. |
| 1992 | Summer | Limited activities. |
| 1992 | Fall | Remaining councils, Practice, Communications & Informatics, and Resource Management are operationalized. |
| | | Further layoffs and cutbacks occur. |
| | | SNAA abruptly withdraws support from the Nursing Governance Model. |
| | | All restructuring ceases within the Nursing Division. |
| | | The previous status quo of a hierarchical structure resumes. |

# APPENDIX B

"Critical Path" of the Nursing Governance Task Force in 1991

| | |
|---|---|
| May | Review of the literature |
| | View of the University of Alberta Hospitals' Quality Improvement Program's video: ***The Business of Paradigms.*** |
| | Consult with persons who have had experience with shared governance in other institutions. |
| June | Bring in outside resources or set up audio of video conference calls to dialogue with other institutions practising a governance model (St. Joseph's, Atlanta; Ranchos Los Amigos, California; RUSH Presbyterian, Chicago; Beth Israel, Boston;). |
| July | Gather input from staff. |
| August | Gather input from staff. |
| | Consolidate input. |
| | Develop/identify a model. |
| September | Refine definition. |
| | Develop a description of committee structure for the Nursing Division. |
| October | Presentation of the model and educational plan to Nursing Council. |
| | Recommend implementation in January 1992. |
| | Nursing Council takes to staff for input. |

APPENDIX C

*Dialogue*

# GROUND RULES

**Listen Generously**

**Speak Straight**

**Be "For" Each Other**

**Honour Commitments**

**Acknowledge & Appreciate Others**

**Be Concerned for Inclusion**

**Be Concerned for Alignment**

## Dialogue Ground Rules

### LISTENING GENEROUSLY

This means learning to listen for the contribution and commitment of the other person and suspending our assessments, judgements and opinions about what they are saying. Listening generously doesn't mean we agree or disagree with what is being said, but that we are committed to the legitimacy of and value in their view.

### SPEAKING STRAIGHT

This means speaking honestly in a way which forwards the action and the conversation. It means being senior to the tendency to edit what we say based on what "we think they will think" and simply express what you are seeing or thinking about the topic under discussion, as opposed to reacting to or attacking what is being said. This includes learning to make clear and direct requests, and to make those requests within specific, agreed upon timeframes.

### BEING "FOR EACH OTHER"

This means believing and committing ourselves to the premise that we are all in this together and "I cannot win at your expense". It means taking a stand for the other person in much the same manner as a coach is a stand for every member of the team. This is the basis for trust and making it safe for each other to risk without fear of censure or being undermined by one's colleagues.

### HONORING COMMITMENT

This means respecting each other's commitments including your own. To relate to each other based on our commitments does not mean we will always succeed or that we will also fulfil every commitment, but it requires we not use the circumstances or the results to invalidate people or their commitment. Committed people may fail in what they are trying to accomplish, but this does not mean they were not authentic in their commitment. This also makes it safe to request coaching or other assistance from others when breakdowns occur (which they inevitably will).

## ACKNOWLEDGEMENT AND APPRECIATION

This means each member of the team commits to continuously acknowledge and appreciate the contributions of others and the team itself, including their best efforts when things don't work out. The value of this is in maintaining a state of completion and is not about "complimenting or giving each other strokes". It also means requesting and receiving acknowledgement from others it it is missing for you.

## BE CONCERNED FOR INCLUSION

This means asking the question, "who else should be included in or has a stake in what we are talking about?" As a practical matter everyone cannot be in every conversation, but they can be included. For example, when someone is missing from a meeting for whatever reason, inclusion means not only informing them what happened and what commitments emerged, but also representing their view to the extent possible in the meeting and requesting their explicit endorsement/empowerment of what happened if appropriate.

## BE CONCERNED FOR ALIGNMENT

This means participating in every conversation with a commitment to build alignment. Alignment does not mean consensus or universal agreement. It means that everyone is either committed, or able, to support the commitments of others. No one is committed AGAINST the direction we are moving. Historically, we generally participate in a conversation to find out if we are aligned, rather than bringing a concern for getting ourselves aligned to the conversation.

All of the above should take place in the context of LEARNING. This means that what we are doing requires more than we as individuals can accomplish, based on what we've learned or demonstrated is possible in the past.

## APPENDIX D

### Questions to Guide Decision-Making for the C.A.R.E. Model

**What** has to be **decided**?
- problem analysis needed

Is this **our decision** to make?
- are we making a decision or giving input?
- who has the final say?

Whose **help** do we need?
- resources for interpretation, facilitators, other departments?

What are the **limitations** to be considered?
- collective agreements
- professional standards
- unit guidelines
- corporate/global decisions
- legislation

Is there a **timeline** for making the decision?
- critical path for when the decision is needed
- will likely influence type of research/resources needed

How will the decision be **communicated**?
- to whom, from whom, by what method?

Does this need to be a **formal process**?
- are there any QI tools/techniques to help make the decision?

How will the decision **contribute to/impact the organization**? Does it **add value**?
- impact analysis, critical success factors

How will we **evaluate** the decision?
- tools, timeline

What **resources** do we need to support the decision?
-financial, human, equipment/supplies, information, other

What will be the **outcome** of the decision?
- end product of the decision

What are the **implications** of our decision?
- effects felt by other departments/staff
- rebound effects in Unit

What if we make the **wrong decision**?
- unlikely if adequate information in planning stages
- recognize when decision is "wrong" and make adjustments

What if we are **unable to decide**?
- require additional resources (information, people) to make the decision

Will the **budget allow** for this decision?
- can this be done with existing dollars?
- cen we reallocate dollars?

Do we have all the **information**?
- fact-finding finding research, financial data, staff opinions

**Who** will this decision **affect**?
- clients/families, staff/peers, managers/facilitators, other health care professionals, support staff, unit/institution

Have we sought **input** from those **affected**?
- team decisions to include other staff

Has this decision been **made before**?
- how can the previous decision help us?

Will the decision **affect professional standards**?
- explicit standards (CNA, AARN, Divisional Councils)
- implicit standards (set by individuals for their own practice)

## APPENDIX E

Dear

I am a graduate student at the University of Alberta and am currently in the process of completing a master's thesis in Education (Educational Administration). My research study is aimed at analyzing the perceptions of the Nursing Governance Task Force regarding the process used to develop the University of Alberta Hospitals Model of Nursing Governance, the C.A.R.E. (Caring; Accountability; Respect; Empowerment) Model. To achieve this, I would like to interview the members of the Task Force to gather their perceptions of the process.

The interview would be taped and be approximately forty-five minutes in length. It would be conducted at a time and place of your choosing. All information will be treated confidentially.

Your participation would be very much appreciated so that a complete picture of the adoption of the model can be obtained. I will contact you by a follow-up telephone call to arrange a time and place. At the time of the interview, I will have you sign a consent form and offer further explanations of the process.

Thank you for your assistance.

Yours sincerely,

Brenda McLean

## APPENDIX F

## CONSENT FORM FOR PARTICIPATION IN RESEARCH STUDY

**Title of Research:**

Perceptions of the Nursing Governance Task Force Regarding the Process Used to Develop the the University of Alberta Hospitals' Model of Nursing Governance.

**Researcher**
Brenda McLean
Master of Education Candidate
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**Advisors**

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Associate Professor
Department of Educational Administration
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Dr. Frank Peters
Associate Professor
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Faculty of Education
University of Alberta
Phone: 492-7607

**Purpose of the Study**

The purpose of this study is to determine the perceptions of the members of the Nursing Governance Task Force (NGTF) regarding the process used to develop the University of Alberta Hospitals' Model of Nursing Governance, the C.A.R.E. Model (Co-operation; Accountability; Respect; Empowerment).

**Procedure**

If you agree to be in the study you will be interviewed by the researcher. The interview will be taped. You will have the opportunity to review the transcribed interviews to verify the information. The questions asked will elicit the following information:

1. Some background information about you such as education, experience in nursing, number of years employed at the University of Alberta Hospitals, and position within the organization (management, staff nurse, union official).
2. What prompted you to become involved with the NGTF?
3. What facilitated the process? What hindered the process?
4. Are the perceptions of the process of staff nurses different than those of management? the unions?

**Risks and Benefits**

The information obtained from this study may help clinical nurses and nurse administrators to better understand a shared governance structure and how a model can be developed. Taking part in this study may not help you directly.

**Voluntary Participation and Confidentiality**

You do not have to be in this study if you do not want to be. If you take part in the study you are free to withdraw at any time. Taking part in the study or withdrawing from the study will not affect your position within the Hospitals. If you wish to withdraw from the study simply tell the researcher.

Your name will not be recorded on the transcribed interviews. An assigned name will identify you. The record of your name and assigned name is kept in a locked drawer. At the end of the study the record is destroyed. The information collected from the study is kept. It may be used for other educational and research purposes, after ethical approval is obtained from the appropriate places. Your name will not be included in any reports of this study, in any articles, or in talks about the study.

If you have any questions or concerns at any time, you are free to call the researcher, Brenda McLean, or advisors, Dr. Beth Young or Dr. Frank Peters.

**Consent**

I, _____, have read this information. I agree to be in the study called, Perceptions of the Nursing Governance Task Force Regarding the Process Used to Develop the University of Alberta Hospitals Model of Nursing Governance. I have had the opportunity to ask questions about the study and my part in it. I understand that I will be given the opportunity to review my transcribed interview to verify the information. The researcher, Brenda McLean, has answered all my questions at this time. I have been given a copy of this consent form.

_____ _____

signature of participant date

_____ _____

signature of researcher date

# APPENDIX G

## Sample Questions to be Asked During Taped Interviews

### A. Demographics:

What is your educational background in nursing?

Have you any educational preparation beyond your basic nursing?

How many years have you practiced nursing and in what aspect of nursing?

How many years have you been employed at the University of Alberta Hospitals?

What position do you hold within the hospitals?

### B. Motivation:

What motivated you to join the Nursing Governance Task Force?

What motivated you to remain on the Task Force?

### C. Process:

Can you recall the process used to develop the model?

Can you recall the decision-making process that the Task Force used?

Can you identify factors that facilitated the process? Why did they facilitate the process?

Can you identify factors that hindered the process? Why did they hinder the process?

What are your overall perceptions of the process used to develop the model of nursing governance?

## APPENDIX H

**Date:**

**To:**

**From:** Brenda McLean

**Re:** Transcript of Interview

Please find enclosed a copy of the transcript of the interview of ..... Make any revisions, additions or deletions on the document and return it to me in the enclosed envelope. I will then make the changes in the original.

If you feel that you would like to expand on any area and would prefer an additional interview, please call me at 438-4118 (home ) or at 494-4987 (work) or 492-8862 (work).

Once again, thank you for participating in my research.